RESTRUCTURING HEALTH SERVICES AND LABOUR:

Management and Union Relations in an English Health Authority

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Abstract

This research explores the state of health service trade unionism in the 1980's and considers its prospects for the future. This is located within the context of trade unionism in general and more specifically within the public services. Historically trade unions have reflected the contours of capitalist work organisations and the social relations within them.The review of British trade unionism in the 1980's therefore considers the impact of institutional factors together with broader social processes upon unions and the "models" of union behaviour which have emerged.

The development of trade unionism in the health service is examined to consider how far it can be understood in similar terms. It proceeds from a review of work organisation and management in the NHS which is used to identify a continuing emphasis by the State on cost-containment in the form of efficiency gains. Attempts to introduce greater "rationality" in bureaucratic forms have confronted the influence of the medical profession in the locally negotiated order. However, more recent changes can be presented as introducing more market-oriented criteria. The possible implications of this new environment for health service trade unionism are considered.

A single Health Authority case study is used to examine the types of opportunities which may be created for alternative models of trade unionism, described in terms of bargaining, professionalising and campaigning. Following some general information on the Health Authority and its context, six selected episodes are used to consider the application of alternative strategies. Each illustrates contradictory pressures to which unions may be subject. Finally, the analytical questions on the relationship of public service work to capitalist work organisation, and the consequences for trade unionism are reconsidered.

CHAPTER ONE

Introduction

One in ten of all British trade unionists work in the National Health Service. The context of their work changed radically during the 1980's under the impact of general management, competitive tendering for ancillary services and a more stringent financial environment. All served to focus greater managerial attention on issues of efficiency and labour utilisation. With the passage of the NHS and Community Care Act 1990, and the establishment of self-governing hospital trusts operating within an "internal market", the prospect appears of collective labour organisation operating in an increasingly commercial environment.

In the economy as a whole, deregulation of the market in the 1980's was accompanied by a deep and continuing decline in union membership. This now stands at its lowest level for thirty years, with one in four of all union members having been lost since 1979 (Bird *et al*, 1992). Union density, at 38% according to the Department of Employment Labour Force Survey, is at its lowest level since before the War. Union membership within the health service, as within public services generally, has meanwhile fared relatively well. The impact which continuing health service organisational change may have upon levels of union membership and its character provides an important starting point for this research.

This requires a more general assessment of why trade union fortunes have reached such a low ebb. Does the decline merely represent a cyclical fluctuation, or is it symptomatic of a more deep-rooted secular trend? Have shifts in the occupational composition of the workforce permanently undermined much of the traditional basis for trade unions? Has legislative hostility to trade unionism simply been the product of an aberrant Government, or does it signify a broader cultural shift away from collective identities?

It is against the backdrop of questions such as these that the policy responses of unions themselves need to be considered. Though rarely raised explicitly, such concerns informed much of the analysis and prescription offered in "models" for union behaviour in the 1990's. Alternative forms these took reflected the "secondary nature" of trade unions (Hyman and Fryer, 1975). "Market" or "business" unionism emerged in the context of unions experiencing the most severe loss of members, those organising manual workers in the manufacturing sector. The two unions most closely associated with this model, the AUEW and the EETPU, between them lost four out of every ten members from 1979 to the time of their merger.

Other union leaders sought to advance an alternative model deemed more appropriate for the growing workforce in the private service sector. Not only has recruitment failed to match the growth in employment, union density in this sector has fallen, from 18.1% in 1979 to 14.4% in 1987 (Waddington, 1992). A notable advocate of a more distinctive strategy has been John Edmonds of the GMB, who emphasised the role of individual representation within a legislative framework providing individual employment protection.

There has been less explicit attempt to articulate a distinctive model for trade unionism in the public services. This is despite, or perhaps a consequence of, the fact that forty per cent of trade unionists now work in them. Among the organisations which represent these workers, considerable divergencies in behaviour have remained apparent. For example, while there have been several major public service industrial disputes throughout the 1980's, some of the biggest membership growth in the decade was achieved by organisations which explicitly rejected the use of industrial action and remained outside of the TUC.

The former leader of one of these associations, the Royal College of Nursing, has argued that preoccupation with the conditions of employment and collective

bargaining was mistaken in the context of "professional" work in which the content of work demanded equal attention (Clay, 1987). The RCN achieved a seventy five per cent increase in membership from 1979 to 1990 and is now the ninth largest trade union in the country. Others argued that public service unions needed to give greater attention to campaigning activities, building public support and alliances with groups in the community (eg Fryer, 1989). Support for such a role has been expressed in several documents produced for the new union, Unison, although as a general strategy for unions it has been questioned (Kelly, 1988).

Alternative strategies are focusing attention on long-standing ambiguities and contradictions in much of trade union practice. In which ways these may be derivative of structural or ideological influences forms an important analytical theme for this research. From this flows the question of whether the secondary nature of health service unions, and public service unions more generally, is such to require a more distinctive model for this sector. This must be approached with some understanding of health service trade union traditions, and the contexts in which they emerged and developed. Of particular relevance in this is the historic divergence between collective organisations. To what extent can these be attributed to variant social and cultural identities, or to the influence of employer behaviour and bargaining structures?

Questions such as these provided the basis in the 1970's for contrasts between the "sociological approach" and the "industrial relations critique", when much of the focus was upon "white-collar workers" (Hyman & Price, 1983). The application of these issues to an historical review of health service trade unionism provides a context for considering how changing experiences in the post-war period may have influenced the current character of health service trade unionism.

Health care work has traditionally been engaged in the production of use values. How far are recent and ongoing changes altering this; do these suggest the

introduction of exchange relations into health services? If so, what consequences might this have for union behaviour? These questions are approached by examining the nature of Government NHS changes, before developing a more detailed focus using local case study material drawn from a single Health Authority. Using a range of individual episodes, attention is given to the origins of organisational change and the nature of union response. Of particular interest is the extent to which this reflected objectives designed to secure influence over the character of change rather than the terms upon which it was implemented. This is considered in terms of the influence upon definitions of union purpose of occupational identities on the one hand, and institutional support for unions from the employer on the other. In this, an approach is taken which aims to draw on the strengths of both the "sociological approach" and the "industrial relations critique".

Throughout, an underlying issue is whether there is evidence to suggest that the restructuring of health care is moving it into a more commodified form. If this is so, it might be hypothesised that NHS trade unions may increasingly be required to adopt a market-bargaining model. Alternatively, earlier identities might be expected to retain a significant residual influence. The case study material is intended to throw some empirical light on these possibilities, enabling some of the analytical and policy implications to be returned to. This is an issue having particular relevance in the context of the formation of a new public service union, Unison.

Analytical framework

An important question running through this research is whether the analytical treatment of trade unions in general is appropriate for those in the health service, and public services more widely. A starting point for this is to consider the characterisation of trade unions, whether this is to be by behaviour, as with participation in collective bargaining, or ideology, as in attachment to collectivist principles. This is an issue which has surfaced in several contexts, as during the 1970's in debates on the interpretation to be placed on the growth of white-collar trade unionism. A second issue concerns the analytical treatment to be given to public services. In particular, do they need to be analysed in ways which emphasis their distinctiveness from the social relations of capitalism? This section concludes with a discussion on the implications of these issues for understanding the nature of public service trade unionism.

The character of trade unionism

Approaches to the growth of white-collar trade unionism during the 1960's and 1970's have been located in two competing camps, represented by the "sociological approach" and the "industrial relations critique" (Crompton, 1977). The latter, expounded by George Bain and his colleagues, emphasised the structural context, particularly the role of employer behaviour (Bain *et al*, 1970) and later the business cycle (Bain and Elsheikh, 1976). The former was far more concerned with understanding differences in character and ideology. These were held to reflect not the institutional features of collective bargaining but, "the commitment of a body to the general principles and ideology of trade unionism" (Blackburn and Prandy, 1965). These were given analytical priority as indicators of "unionateness".

Some parallels can be drawn with continental European writers, who have given more emphasis to indicators of active participation rather than membership which may be largely passive. Unlike much of the traditional focus for British industrial relations in its examination of membership growth and density, German writers have been concerned with notions such as a "willingness to act" (Offe and Wiesenthal, 1980), and sought to use strike activity as a measure of union strength (Muller- Jentsch, 1985).

The importance of which indicator is to be used is considerable when the 1980's are considered. The issue of strike activity has particular complexities in the context of public services, and is returned to later. At this point it is useful to consider further if participation in collective bargaining provides a sufficient indicator of unionisation, or whether a broader ideological attachment to collective principles is also necessary. This was the view taken by Blackburn and Prandy (1965) who identified a series of characteristics regarded as representing "unionateness". Briefly, these were; self-declaration and registration as a union, affiliation to the TUC and Labour Party, independence from employers, collective bargaining and protection of members as a major function, and a willingness to take industrial action.

There are several problems with adopting this type of approach. Not least is the difficulty in distinguishing collective action as an indicator of ideological purpose from its use as a strategy for individual advancement. Collective identities within the wage labour relationship can in any event be held at a range of levels, with the reference point being the working class as a whole, or more narrowly conceived in terms of a craft, profession or particular work group. This can give rise to a range of cultural and ideological expressions, as EP Thompson noted for an earlier period:

> The class experience is largely determined by productive relations into which men are born - or enter involuntarily. Class-

> consciousness is the way in which these experiences are handled in cultural terms: embodied in traditions, value-systems, ideas and institutional forms. If the experience appears as determined, class consciousness does not (Thompson, 1963).

This point has particular relevance in the context of post-modernist claims concerning the disintegration of traditional social identities. There is no *a priori* reason for assuming greater heterogeneity implies a wholesale transformation of existing social categories. As Offe has written:

> It would of course be mistaken, or at least premature, to diagnose or predict a general "transformation of values" affecting all strata and age groups of the working class. Such uniformity on the basis of "new" cultural values is, we suggest, not at all to be expected. Arising out of conditions of economic crisis and tendencies of cultural change, the problem consists rather in an attenuation of the economic and "moral" divisions within the working class. The result, in other words, is a growing heterogeneity in the objective situation of different groups of employees, as well as their subjective perceptions and interpretations. (Offe, 1985, p 154).

For this reason, it becomes more important to avoid too narrow a definition of union character. Collective activity by employees can generate a variety of forms, as was evident in the notion of "Associations of Producers" used by Sidney and Beatrice Webb (Webb, 1920). Equally, an approach which defines a trade union in terms of participation in collective bargaining alone may be just as narrow. While this has represented the dominant historical tradition, it has not been the only alternative available. Because unions may exhibit a range of characters and behaviours, the question becomes one of seeking to understand different processes of development. Of particular relevance is the influence of social relations other than those of capital and labour.

Trade unions derive their "secondary nature" from their emergence in the context of capitalist social relations (Hyman and Fryer, 1975). In this, capital may be seen as the "primary organiser" of labour (Offe and Wiesenthal, 1980). This

should not be taken to mean that trade union *behaviour* is wholly determined. To do so would be to imply, as one reviewer wrote in a different context, that, "management makes industrial history and unions follow" (Aronowitz, 1987, reviewing Kochan *et al*, 1986).

The notion of agency is an important one, and is given recognition by Offe and Wiesenthal in their description of the "willingness to act" by members requiring a "dialogical" pattern of membership communication, with member involvement in decisions. In Gramsci's words:

> The trade union . . . becomes a determinate institution . . . to the extent that the strength and will of the workers who are its members impress a policy and propose an aim that define it (Gramsci quoted in Hyman, 1983).

For some writers such policies and aims could never extend beyond the boundaries set by capitalism. In Perry Anderson's view, "trade unions do not challenge the existence of society based on a division of classes, they merely express it" (Anderson, 1967). This research is not about the revolutionary potential of trade unions, but does seek to consider whether their character may derive from sources other than those set in the context of capitalist wage labour. Here it is necessary to give some attention to alternative conceptions of union purpose in terms of what can be broadly described as industrial and political objectives.

Nineteenth century craft unionism provides much of the basis for definitions of union purpose in terms of bargaining activities over both job conditions and content. Such political action as emerged was frequently designed to achieve the organisational security for this to take place. The threat to union funds in *Hornby v Close* in 1867 prompted action by the Amalgamated Society of Engineers in a way that the Master and Servant Laws had not, even though the latter had allowed the imprisonment of workers for breach of employment contract. Generally, and continuing into the twentieth century, trade union engagement in political activities

was a means of supporting bargaining objectives and activities, as in the stimulus which the *Taff Vale* judgement provided for the creation of the Labour Party.

Some prominent craft unionists had become involved in wider social policy issues, as with Robert Applegarth's appointment to the Royal Commission on Venereal Diseases in 1871. The response to this by his Executive of the Carpenter's Society was to urge his resignation, castigating him for his involvement in a, "loathsome subject" which did not "specially affect" their members.

Attitudes by many leading trade unionists to early health reform similarly reflect the objective of representing members' rather than class interests. The Liberal Government's National Insurance Act of 1911 won support from the majority of union leaders for its provision of contributory benefits for workers, though it did not provide for dependents during periods of sickness and unemployment. Neither did it address wider issues of health provisions such as the lack of maternity care and TB sanatoria (Iliffe, 1983).

These were issues being addressed by some new Labour Councils elected at this time. Of particular note is Poplar Council, elected in 1919, which introduced free milk for expectant mothers and appointed a TB officer, and which possessed a strong influence of "new unionism". This included a branch secretary and a former branch secretary of the dockers union, a former district president of the dockers, the General Secretary of the National Union of Vehicle Workers, the secretary of the Bow branch of the Postmen's Federation, the Secretary of Poplar Trades Council, and the Bow branch Secretary of the Engineers among many other activists (Branson, 1979).

An unwillingness on the part of many older craft unionists to engage in wider political activity has been attributed to the "aristocracy of labour" thesis. Whatever its deficiencies, it does serve to highlight differences on definitions of purpose within organisations of the working class which reflect occupational divisions. An

example of this is provided in the 1889 TUC meeting, when leaders of the Miners Federation of Great Britain joined with the majority of other unions to defeat Keir Hardie's resolution for a general eight hour day for all workers. They then went on to successfully appeal for Congress support for an eight hour day for the miners (Muller, 1977). The sectional commitment of the miner's leaders in this also reflected an ideological rejection of a more radical politics.

This standpoint continued when in 1922 JH Thomas, General Secretary of the NUR, blamed Labour's poor showing in the London County Council elections on a, "revolt against the kind of Poplar methods of administration which certainly alarmed people" (Branson, 1979, p132). When Labour did win control of the London County Council it was under the leadership of Herbert Morrison, held up by the national Labour Party as a model of moderation (Cole, 1948). Of particular interest is the fact that this gave rise to a significant dispute over working hours with the Guild of Nurses, part of the National Union of County Officers.

In addition, Labour's attempts to improve London's municipal hospitals appear to have been carried out in a highly bureaucratic manner. A general grievance was voiced by one member of the Guild of Nurses:

> We have become mere numbers in the machine . . . and carry out the instructions of someone who does not even know where the hospital is situated. (quoted in Carpenter, 1988, p216).

Despite these early indications of the potential consequences of more centralised and bureaucratic control, the LCC model exerted a major influence on Labour's post-war policies. Meanwhile, the TUC lent its support to the BMA, its partner over the National Insurance Scheme (Illiffe, 1983). In the structuring of public services there was little room for crossing the boundary between political and industrial roles through industrial democracy. Aneurin Bevan, having a background in both trade unionism and left Labour politics, rejected requests for the

inclusion of non-medical staff on Hospital Management Committees, asking where such moves would stop (Stacey, 1988).

Post-war social democracy consolidated the separation of the industrial and the political. Within the Labour Party, Crosland in particular saw a distancing from the unions in the wake of the 1959 election defeat as a means of capturing a broader base of electoral appeal (Minken; 1978). This provided the context for the development of post-war health service trade unionism: the new structures provided for input from staff organisations primarily on wages and conditions issues, while health services and their delivery came under the control of medically dominated management committees.

These outcomes would seem to lend support assessments of the 'secondary nature' of trade unions, although as has been described, other traditions emerged which do not appear to have been principally determined by collective bargaining contexts. Can health service unions today draw upon such traditions, concerned with securing wider improvements in the "conditions of labour"? Before this question can be addressed it is necessary to consider the nature of the services within which they operate, in particular to ask the further question of what sets of social relations are important within the 'primary' organiser of health care labour?

The analytical treatment of public services

The claim has recently been made in one introductory text to industrial sociology that:

> There are differences between . . . private and public sector employment, but the nature of these differences is something which has to be established empirically, not asserted *a priori*. (Brown, 1992, p189-190).

The later case study material is intended as such an empirical contribution, but this must be approached through some prior conceptual questions. Of particular importance is whether public services are seen to follow a different logic from that of capitalist accumulation. If this is so, how are they to be analysed? Running parallel with these questions are ones concerning the relative analytical priority to be given to class and gender.

The issue of whether public services need to be understood in terms of a different logic from that of capitalist accumulation has been addressed by several writers (Cousins, 1987; Joyce *et al*, 1988; Mailly *et al*, 1989). Massey (1984, p182), for example, has suggested that the state provision of health services, and their non-dependence upon the process of capitalist accumulation, has created less geographical variation than has occurred in the private sector. Claims for such distinctiveness have drawn on Offe's distinction between the productive and allocative functions of the state, and the suggestion of a "decommodification" of social relations within the state welfare sector (Cousins, 1987).

Yet as Cousins and others observe from the 1980's, the influence of market relations has become increasingly evident. This can be interpreted as reflecting the inherently contradictory nature of the welfare state in capitalism (Offe, 1984). Some writers have argued that a consequence of this has been that public service managers, "are nevertheless constrained to act as "capitalists" in respect of the organization and control of their labour force" (Crompton and Jones, 1984, p214). This approach in many respects mirrors that of earlier structural accounts of public services such as health care. In the context of debates over professional control, Navarro argued from a Marxist perspective that the "health industry", "is administered but not controlled by the medical profession. . . . power is primarily one of class not professional control." (Navarro, 1975).

Such capital-logic accounts have been dismissed by Mailly *et al* (1989), who maintain that public services continue to operate differently from other sectors,

attributing this largely to the political context in which they operate. In this the writers focus mainly upon the role of national Government, but such a definition of the political sphere is unduly constraining. Again it is useful to turn to Offe for a more satisfactory approach, one which describes the political context at three tiers or, "cumulative arenas of conflict". (Offe, 1984).

The first of these is that of decision making within the state apparatus, "But this is by no means the only level at which political power is generated, distributed and utilized". (Offe, 1984, p159). This is seen to occur within the second level, described as:

> a *matrix of social power* according to which some social classes, collective actors and other social categories have a greater chance of shaping and reshaping political reality, opening or closing the political agenda, than others. (Offe, 1984, p160).

Power is not static and, "the struggle for the *redistribution of social power* is what takes place on the third, and most fundamental level, of politics." (Offe, 1984, p160). Analytically this provides a useful tool with which to understand the NHS as a political organisation. Public service managers have to operate in a context in which attempts by Government to recommodify state services confront the "matrix of social power" formed, and reformed, around those services. The analytical task is to generate a framework within which influential agents and forces within this process can be conceptualised.

Significant in this is the fact that, "the production of welfare services involves the collaboration of professional providers in the determination of goals" (Cawson, 1982). This has been used by several analysts of health care organisations to emphasise the degree of control held by medical staff. At a "macro" level this aspect influenced the work of Illich (1975), while also providing the context for the original use by Strauss (1963) of the "negotiation of order". This latter approach

suggests an encouraging line of enquiry, while recognising the criticisms made of it for neglecting inequalities in power, and the need for it to, "become much more politically, structurally, and historically grounded." (Day and Day, 1977).

This is sought within this framework by placing health care organisations within the overall structure of capitalist social relations, while accepting that these may not be sufficient to account for its character. For this, it is necessary to take account of ways in which power is distributed within the organisations, and upon what sources of support it may rest. The basis of medical dominance has been attributed to the nature of the early relationship with the patient (Johnson, 1972). Johnson, however, argued that increased state provision of services fundamentally altered this relationship, undermining any future opportunities for the experiences of the "classic" professions, medicine and law, to be emulated.

This interpretation derived from the nature of contractual relationships between the independent practitioner and their clients. Though this has largely gone, a distinguishing characteristic of the labour processes within health services continues to reflect other, non-contractual, aspects of this relationship. Much of public service work carried out with people inherently possesses a degree of indeterminacy arising from the individuality of patient's or client's responses. The term "sentimental work" has been used to describe such work (Strauss, 1982). It has further been suggested that in the context of the NHS, this may place constraints upon the extent to which managerial desired rationalisation can be achieved (Morgan, 1991). This issue can be seen to arise in controversies over "task-centred" and "patient-centred" approaches to nursing (Mackay, 1989).

This suggests that the labour process in welfare work remains analytically distinctive even where state provision has become the norm. Whatever the term used to describe it, the notion that work involved in caring for other people is in at least some ways distinctive from the capitalist labour process has a further impor-

tant aspect. Mostly it is performed by women. This reflects the transference of roles within the unpaid domestic sector into the wage labour market.

It is untenable to explain such occupational divisions as being a consequence of capitalist social relations alone. In this sense, capital cannot be held to have historically been the primary organiser of health labour, or at least not independently of the role of gender. Some version of "dual systems theory" is needed to recognise that workers sell their labour power in jobs which in many cases are already segregated by gender (Davies and Rosser, 1986).

None of this is to suggest that capitalist social relations have not made a firm imprint on health service organisation. Rather it is argued that these influences may be constrained by the different nature of the labour process within health. A further consequence of the nature of health work is a particular need to take account of gender relations alongside class ones. These issues may have particular relevance in understanding the local "negotiation of order" within health care services (Strauss, 1963). Here attention returns to considering some of the implication of these issues for public service trade unionism.

The consequences for public service trade unionism

Differences in the behaviour of collective labour organisations reflect a variety of structural and cultural influences, including the fact that the workforce will have been brought into being within the context of capitalist social relations and organisation of work. The influence of capitalist priorities may now be extending to those public services which grew rapidly in the post-war period to a substantial extent outside of such relations. This must be qualified by the recognition of important counter-tendencies. Significant in this is the status of professional groups and the inherently indeterminate nature of much caring work. While this might suggest

obstacles to a process of capitalist-type rationalisation, consequences of the gender-structuring of much of this work should not be ignored in this process. Nevertheless, it can be maintained that analytically public services remain, *to a degree*, independent of capitalist social relations.

This suggests the possibility of divergent strategies from organisations representing staff within them. This links with earlier debates which focused on the likely development of professional organisations. Some writers saw the development of collective organisation among professional groups as possibly leading to militancy but more likely to produce a professional ethos in which the defence of privilege and distinctiveness would make an alliance with labour unlikely (Bell, 1974). Others saw rising levels of education producing dissatisfaction with the constraints of capitalist enterprises (Gorz, 1967), creating in the view of Touraine and Mallet the prospect of alliances between professional and manual workers (Gallie, 1989). Yet others stressed the "proletarianisation" of professional workers themselves as managerial rationalisation reduced their autonomy (eg Bellaby and Oribaber, 1977).

The focus of many of these debates was on the likely impact of processes of capitalist rationalisation upon professional autonomy. What may now be emerging as a more significant aspect is the possibility of conflict arising where the production of use values becomes subject to a process of commodification. This might suggest an alternative form of alliance, not so much between professional and manual groups as between health care producers and users. Flowing from this are particular implications for the notion of "unionateness" and "willingness to act".

Offe and Wiesenthal (1980) emphasised "willingness to act" as a characteristic distinguishing worker organisations from other interest groups which required only a "willingness to pay". Earlier, this was compared with the way in which Blackburn and Prandy (1965) employed strike activity as an indicator of unionate-

ness, and Muller-Jentsch (1985) identified it as a component in a measure of union strength. Analytically, these are founded on the basis of capitalist work relations in which the withdrawing of labour presents a means of obstructing production, and hence the extraction of surplus value.

Two points on this may be made in relation to public services. Firstly, industrial militancy within them may be better described as a political rather than an economic sanction. The second flows from drawing a distinction between workers engaged in the production of use values and those producing exchange value, in terms of the nature of the relationship with consumers. Offe and Wiesenthal's notion of a "willingness to act" is an important one for differentiating worker organisations from others but it may need to be given a broader meaning than industrial militancy alone. In itself this provides a limited indicator of the strength of public service trade unionism.

A review of current trends in employment and social stratification concluded with the observation:

> The form taken by the collective organization of non-manual workers has developed in the context of, and has been heavily influenced by, the powerful traditions of trade unionism among British manual workers (Gallie, 1989, p489).

The analytical issues discussed here suggest the possibility of alternative future scenarios for trade unions in the NHS. Firstly, concerning the labour process, managers increasingly constrained to act "as if" they were capitalists, having the effect of reducing the distinctiveness of health work. Alternatively, this process may be constrained by the inherent indeterminacy of health work. Secondly, health care services may be becoming subject to processes of commodification which are undermining the traditional nature of power relations within them. Alternatively again, this process may be constrained by the continued production of use values.

If an extension of exchange relations, and the application of more capitalist work techniques, is anticipated, then the comment by Gallie would be likely to retain its relevance, possibly in the emergence of a more market-based bargaining model. On the other hand, if health care services are viewed as maintaining a degree of distinctiveness, then this may suggests a need to rethink existing models.

Research Methods

The thesis falls into three parts. The first examines pressures on British trade unionism during the 1980's, and considers how responses to these might be categorised. The second explores aspects of the development of the National Health Service and forms of collective organization which emerged within it. The third provides a more detailed local 'case study' in which these themes are considered in a more focused context.

For the first section it was necessary to draw upon a range of primary and secondary sources. Considerable use was made of official statistics for data on occupational changes within the labour market, and measures of union membership, density, and activity. Of particular value in this were statistics published by the Department of Employment and the Certification Officer. Without disregarding the deficiencies of such sources, as in data on industrial stoppages for example, they can assist in providing a useful indication of general trends.

This has been supplemented with evidence drawn from other bodies, including the TUC and individual unions. For the review of union policy responses, sources included individual union and TUC policy documents and statements, articles by prominent trade union leaders, together with union journals and other publications. In conjunction with the use of official statistics, these provided a means of identifying factors perceived as being significant.

The second section similarly required both primary and secondary material, this time relating to health services and its trade unionism. For the former, use was again made of official statistics, in this case primarily those published by the Department of Health. The ways in which these are presented sometimes limits their value, but despite this they provided an important source for identifying aggregate trends. These related to issues such as changing patterns of expenditure, evidence on labour productivity, and shifts in the composition of the workforce. In addition to these sources, it was possible to incorporate details from various inquiries and reports into aspects of the health service that have been published over the years.

On trends within health service trade unions, use was made of union publications, including journals, conference reports and discussion documents. Secondary sources included published histories of the NHS and its trade unions. In addition, although the national situation did not form the major focus for the field work, one interview was conducted with a national officer of a health service union.

The following explains the approach that was taken for the case study. The material which was collected might more accurately be described as a series of case studies, but for reasons explained later, as well as for convenience, it is referred to as the case study material. The purpose of this part of the reasearch was to provide a more focused empirical opportunity to consider some of the categories of union strategy and behaviour derived from the previous two sections. The claim for validity of case studies is not based upon them being representative, but that they exhibit some general theoretical principles (Silverman, 1985). Their importance lies in the nature of explanation which is used, designed to identify the nature of connections between processes. The case study material here is included to provide a

focus upon processes of change within the National Health Service at a local level, particularly in terms of whether these were causing it to become less analytically distinct from capitalist social relations. No claim is made for its typicality other than as a means of investigating these processes.

The case study is based on several "sub" units, although this is not principally to overcome the criticism sometimes made of case studies of "N=1". They are used as a means of comparison but within a context of their organisational integrity. This was important in indicating whether general processes may be having variable impacts upon differing occupational groups. Much of the methodological rationale which was used draws upon points made on case study standards of rigour by Stoecker (1991).

A case study must avoid becoming simply a collection of descriptive anecdotes, and an essential requirement in this is adequate design of the research frame. Of particular relevance for this is the role of theory, historical perspective and choice of methods. In line with what has been noted above about the purpose of case studies, Stoecker (1991) argues that theory must determine which questions are to be asked, and consequently, the structural boundaries of the research frame. The broad theoretical issues upon which the current case study is founded have been described above: the relationship between the restructuring of labour and trade unionism, and the welfare sector in capitalism. Stoecker's related requirement is that the theoretically generated questions must inform the structural and historical boundaries of the research frame: this is described in more detail in application to the case study in Chapter Five. The need for theoretically generated structural and historical boundaries for the research frame leads to Stoecker's third criteria: the need for a variety of research methods.

Here it is important to give some background to my own involvement in the Health Authority being studied. I had been employed by the Health Authority, as a

hospital porter, for the period from 1978 to 1985. In 1981 I became a COHSE steward, and Branch Secretary in the following year. I retained that position, and others, until I left in 1985 to go to Warwick for the MA in Industrial Relations. Although most of the episodes being used in the case study occurred after my own direct involvement in union activity in the Authority had ceased, many of the other processes described, including the introduction of competitive tendering and of general management, happened earlier. Questions which I wished to raise were inevitably influenced by my own earlier experiences.

In any event, direct personal involvement was re-established in 1990 when I was appointed as TUC nominee to the Plymouth Health Authority. This ceased upon the reorganisation of Health Authority membership in 1991. However, I was then appointed to the local Community Health Council as a nominee of Plymouth City Council. Each of these roles provided differing opportunities to identify issues and obtain information surrounding them. It nevertheless raised issues concerning the ethics of research.

While in formal interviews with managers my role as a former union representative and current researcher was accepted, by the time I had become a Health Authority member much of this stage of the research had been conducted. I was now in the position of a participant-observer, having, "unique access to the otherwise 'closed world' of a social group." (Layder, 1993). In general, I decided that it was legitimate to incorporate such experiences into the research. Although it does raise the important issue about informed involvement by those who are being researched, there were two main reasons for my decision. The first arose from the fact that as I had already been engaged in a more formal stage of research within the Authority, and my role in this had been understood. The second was the virtual impossibility of discounting the evidence I was coming into contact with once I was aware of it.

Before and during the period of my Health Authority membership I had many opportunities to attend union and other meetings. In addition, I have had access to many policy documents and statements produced by both management and unions, as well as minutes of joint meetings. Formal interviews were conducted with ten managers and an equal number of union representatives. The former included general managers, clinical managers (mainly within nursing) and personnel officers. The latter included branch officers, stewards and full-time officers. All of the interviews were conducted on a semi-structured basis.

Aside from the formal interviews, many opportunities were taken to talk with a wide range of individuals. This was regarded as being of considerable importance. Although the case study was being conducted within a certain analytical framework, it was vital to have a sensitivity to the perceptions of those involved. In this, it was important to recognise criticisms that have been made of field work research which allows formal theories to dictate, "before empirical examination, presumed relevancies in problems, concepts and hypothesis" (Glaser and Strauss, 1971). From talking to a wide range of health care staff, many insights, views and feelings emerged which were essential in developing a view of their own construction of their social world. This was not the main focus for the research, but nevertheless represented a vital element.

The combination of research methods, while meeting the criteria advanced by Stoecker, clearly makes it unreplicable. However, in terms of its rationale this is not regarded as a deficiency; instead opportunities have provided a relatively unique opportunity explore a case study determined within theoretically informed structural and historical boundaries.

One further research method which I gave considerable consideration to using was some form of survey of union members. Eventually I decided against this. My objective would have been to have gone beyond perceptions of union rep-

resentatives to identify the attitudes of "non-activist" members to the importance of issues being dealt with and their relative priority. Even though this was not the main focus for the research, as noted above, it was important in providing a deeper context.

After considering results of such member surveys, some of which are reviewed in Chapter Two, I came to the conclusion that with limited resources I would be unlikely to add to the general understanding of member's attitudes. Furthermore, in taking opportunities to talk to staff, not all of whom were active in their union, alternatives means of identifying these were emerging. Because of the range of people I came to know during my differing forms of association with the Health Authority, I felt able to gain a good understanding of issues which were generating greatest concern. This was not in any form quantifiable, but my view was that any alternative, within the resources, would have been of little more value.

A remaining question is whether my involvement undermines the "objectivity" of the research. This is a familiar issue addressed by many others. On this, I should state that I hold a commitment to the principles of trade unionism, and to the value of a publicly funded and accountable health service; commitments which inevitably influence the choice of research questions asked as well as many of the conclusions drawn.

More than this, much of the original motivation to conduct the research came from my personal experiences. In addition to my own trade union activity, a period in the mid-1980's and since working as a part-time WEA tutor in Trade Union Studies, encouraged me to think about the nature of trade union education and the purposes for which it was designed. A recurring question for me became whether the frequent emphasis upon bargaining skills provided a sufficient resource for union representatives in the changing climate of the 1980's.

This experience reinforced questions I had in my mind as a consequence of my own period as a lay representative. To take one example, personal involvement

in negotiations over staffing changes which were arguably to the disadvantage of women involved (described more fully later), encouraged me to think critically about the processes and outcomes of bargaining strategies. As Stoecker argues, attachment to the subject being researched should be regarded as a source of strength rather than weakness.

Structure of the Thesis

Chapter Two identifies and discusses key sources of change acting upon unions in the 198's, including compositional changes in the workforce, managerial strategy and Government policy. The material is organised in a way which allows alternative accounts for union decline to be considered, particularly in terms of the predominance of "institutional" or "social" factors. The assessment is made that employer and Government behaviour provides a necessary but insufficient explanation for union fortunes. Attention must also be given to the attraction which unions hold for different occupational groups, and the ways in which their definitions of purpose come to be socially constructed.

This leads to a review of models advanced by unions and prominent union leaders during the last decade. These are considered under the heading of market, representational, professional and campaigning trade unionism. They are discussed both generally and with specific attention to their potential relevance to public services.

Chapter Three provides a selective review of the development of the NHS. The main objective is to consider how valid are claims that it is distinctive from the social relations of capitalism. Particular emphasis is given to describing increasing control by the State over finance and efficiency. State control of pay through highly

centralised arrangements for pay determination was introduced within a context of a high level of medical control at local level, and consequences of this for the organisation of work are considered. Addressing differences between the general and psychiatric hospital sectors, attention is given to trends in labour recruitment in the 1960's and 1970's.

There is emerging evidence from the 1980's of a more strategic intention to restructure health services and labour within health care. Financial pressure have been a significant spur to organisational change, but until recently both the scale and the pace of change has been less than in many other sectors. This may suggest that despite the greater evidence of commercial pressures within the NHS, their impact remains to some extent constrained.

Chapter Four describes the variant historical traditions of collective organisations within the NHS. Particular attention is given to developments among nursing staff, a discussion on which allows consideration to be given to the influence of class, gender and organisational context. This provides a background to address the growth of trade unionism in the late 1960's and 1970's, and the form which it took. Reference is made to explanations which have been offered for this, notably the impact of incomes policy, the bureaucratisation of management and the 'deskilling thesis'.

Changes occurring in the 1980's are discussed in terms of their consequences for forms of union activity. While aggregate union membership and union density has remained relatively high, differences in experiences of individual organisations are discussed. These are highlighted in terms of the models described in Chapter Two.

Chapter Five provides a context for the case study material. Beginning with an explanation for the choice of approach, it describes social and economic features

of the Plymouth area and their impact upon the character of local trade unionism. Following this, material on the Health Authority includes a description of important organisational and managerial changes. Mainly this is intended to provide necessary background material for subsequent chapters.

A review of trade union organisation within the Authority includes an account of the major organisations, their areas of influence and aspects of their local organisation. Much of the formal negotiation around the issues described took place through joint union machinery and an account is also given of changes in the form that this has taken.

Chapter Six uses two examples to consider the implications of new opportunities for local bargaining. The first is drawn from catering services and the second from nursing. In both cases changes to work arrangements designed to secure savings were initially resisted by unions, but as this proved unsuccessful attention turned to bargaining over the terms of change. The examples are described in terms of the origins, processes and outcomes of change, with attention being given to differential experiences.

Bargaining activities could increase reliance upon employer support, but outcomes were also influenced by the character of existing union organisation. Although financial and managerial changes served to encourage new opportunities for bargaining, this was also highly constrained by the political relations within the health service.

Chapter Seven examines two examples from within non-general hospital nursing where issues concerning conditions of employment became linked with those of service delivery. The first example arose from staff opposition to management changes to planned developments in mental illness services, the second con-

cerned management intentions to reduce the role of NHS provision in mental handicap services.

The defence of jobs and employment arose in each, but in a context where the form of service delivery became a major issue of dispute. The chapter considers whether union attempts to gain involvement in these broader issues suggests an alternative to a more market bargaining model.

Chapter Eight describes two campaigns which were organised to generate public support during periods of conflict with management. Unions maintained a high profile public opposition to the planned replacement of an NHS hospital by a private company, but were unwilling to engage in a campaign orchestrated by medical consultants in opposition to management plans for a self-governing trust. The reasons for this difference are discussed and located in the context of competing pressures to which unions may be subject. Of particular importance was the need to gain recognition for bargaining purposes from the employer.

The Summary and Conclusion reviews the case study evidence in the context of earlier themes. Some theoretical and policy implications are discussed, with the assessment that current pressures may be encouraging the adoption of a market model but this is likely to prove inadequate to meet the needs of trade unions within the health service. Some concluding comments are made on whether this reflects the continued distinctiveness of health work, or a more general limitation of the model itself.

CHAPTER TWO

TRADE UNIONISM IN THE 1980's

Writing in the early 1980's George Bain and Bob Price predicted that, "all other things being equal", anticipated workforce restructuring would reduce union density from its 1979 level by 3.7 percentage points by 1990. This was qualified by the observation that the direction of union growth, "will depend . . . upon the crucial inter-relationship between economic forces, employer policies and government action" (Bain and Price, 1983, p33).

The actual percentage point decline in union density by 1990 was however almost five times that predicted by Bain and Price. Similarly, Waddington (1992) notes that predictions made by Carruth and Disney (1988) on the influence of the business cycle have consistently overestimated the likely levels of union density for the years since 1983. How is this to be explained?

A recent Open University course book intended to, "examine the social and cultural spheres", of modern society makes slightly more mention of transvestites than trade unionists (Bocock and Thompson, 1992). The implication is that the role unions play in the lives of their members is diminishing and being replaced, particularly among younger people, by more diverse and individualised consumer identities (Willis, 1990). This approach, placing trade unionism in its wider cultural setting, mirrors that adopted by many labour historians for earlier periods. As Gareth Stedman Jones wrote of London working class culture at the end of the last century:

> The growth of trade unionism on the one hand and the new working class culture on the other were not contradictory but inter-related phenomena (Stedman Jones, 1974).

Does it then follow that the decline of trade unionism is symptomatic of a deeper cultural change? Alternatively, is it principally a consequence of changes in its structural environment? These questions parallel those of earlier debates over the origins of union growth, particularly between the "sociological approach" and the "industrial relations critique" (Crompton, 1977). The issue now to be addressed is whether the evidence from the 1980's provides any insights into the importance which should be given to economic, political and institutional factors on the one hand, and the social, cultural and ideological on the other.

At the outset it should be noted that rising unemployment in the early 1980's had a profound impact on levels of union membership. In the words of one writer reviewing the period, this:

> suggests that the major source of trade union decline can be attributed to structural constraint rather than to any significant erosion of allegiances to trade unions on the part of employees (Gallie, 1988, p476).

The exclusion of unemployed workers from measures of union density allows this assessment to be partially tested. The effect is indeed to considerably reduce the scale of decline. While from 1979 to 1983 the fall in "labour force density", including the unemployed, was from 53.4% to 45.6%, the comparative figures for "employment density", excluding the unemployed, was from 55.8% to 52.3% (Waddington, 1992). However, this only holds true for the early years of the decade. By 1987 the level of employment density had fallen to 46.3% (Waddington, 1992). In other words, membership decline continued in a period of employment growth, albeit at a slower rate.

Whatever the merits in challenges made by Kelly (1988) to the more cataclysmic predictions of trade union fortunes, doubt is cast upon his more optimistic assessment that trade unions had generally weathered the recession well. His expectation that union fortunes would wax again as the economy moved out of

recession was not generally born out. To try and understand the reasons for this it is necessary to go beyond the aggregate data.

In the early 1980's, job losses were caused disproportionately by the impact of closures of large manufacturing plants (Millward & Stevens, 1986), while employment growth in the later part of the decade was smallest among male full-time workers. Employment shifted away from the traditional bed-rock of union membership and towards what the TUC described as, "the more difficult to organise sectors, particularly private services" (TUC, 1988).

Whereas for much of the post-war period there had appeared to be a gradual convergence towards higher levels of union density, the 1980's showed increasing sectoral divergence, as shown in Table 2.1. Of particular relevance for the current research is the widening difference between the private sector, including manufacturing and services, on the one hand, and public services on the other.

Table 2.1: Trade union density by sector, 1979-1987

	1979	**1980**
	%	%
Public sector	83.7	81.7
Manufacturing	72.9	60.1
Construction	41.4	29.8
Private services	18.1	14.4

Source: Waddington (1992)

The following discussion reviews aspects of change in the institutional, structural and cultural context within which unions operated in these sector during the 1980's. Although a clear dividing line cannot be drawn between the two, the discussion is structured in terms of institutional and social forces. This account is followed by a review of union responses to the challenges they faced.

The Institutional Framework: the role of employers and government

The influence of employers upon the decline in union membership in the 1980's is acknowledged by both Hyman (1989) and Waddington (1992), although neither identifies it as providing more than a partial explanation. A far more significant explanatory role has been given to employers in an American account of developments in industrial relations (Kochan, Katz and McKersie, 1986). A three-level model is used to claim that collective bargaining, conducted at the middle level, is being squeezed out by developments at the top and bottom levels. Underlying anti-union attitudes among managers are seen as having been given opportunities for expression in a harsher economic climate, while the growth of human resource management has displaced traditional personnel functions in the workplace. At the very least this model provides a convenient framework for considering the impact of institutional changes upon unions.

In Britain it is difficult to conclude that corporate policy has moved towards a wholesale rejection of trade unionism. There may, however, have been notable differences between large and small employers. From the Industrial Relations Research Unit survey of two hundred and twenty nine manufacturing establishments employing over two hundred and fifty full-time workers, Edwards (1985) concluded that, "*managements in large firms* have not been engaged in a systematic attack on unions." (emphasis added).

Kochan *et al* (1986) attributed anti-union corporate strategy to the allegedly poorer economic performance of unionised establishments. These were claimed to have substantially higher labour costs than their non-union counterparts. Case study evidence has been used to substantiate such claims, both in America by Kochan *et al* and in Britain by David Metcalf, but this has been severely criticised for misinterpretation and unjustified generalisation (Nolan & Marginson, 1988). Con-

flicting results produced by case studies underlines the need to place individual episodes within their industrial relations context (Freeman and Medoff, 1984). The importance of this can be illustrated by considering Kochan *et al*'s broad assertion that unionisation imposes "productivity constraints" upon employers.

Although Metcalf concluded from Edwards (1987) that, "managers in non-union plants claim to have higher productivity than their unionised counterparts", those managers in the IRRU survey failed to identify unionisation as a significant problem. The proportion who mentioned union restrictions or overmanning as an internal constraint, fewer than seven per cent, was slightly less than that which identified the quality of management. Similarly, there is little corroborative evidence for Kochan *et al's* claim that company investment decisions have favoured non-union plants. As Nolan and Marginson (1988) comment on the work by Metcalf:

> Citing recent econometric evidence, he suggests that there is "a bit of a puzzle" because unionised firms do not appear to invest less than non-unionised firms. (Nolan and Marginson, 1988).

Of course there have been notable examples of anti-union corporate policy in Britain, with both News International and P&O providing instances where employers were prepared to go to great lengths to break existing union organisation. However significant in themselves, these tended to be the exceptions rather than the general rule. A far more frequent response from British employers has been to alter the nature of existing bargaining relationships rather than to reject them altogether. This is illustrated in remarks made by the Director General of the Engineering Employers Federation on the advantages of "single union agreements". These, it was suggested, enabled an employer:

> to select a moderate and progressive minded union with which he can agree to operate at the outset an industrial relations cul-

> ture embracing all the different aspects . . . that is, employee involvement, harmonisation and flexibility of labour. (quoted in McIlroy, 1988, p193).

Although the impact of single-union agreements has been largely limited to greenfield sites, they can be seen as representing a more generalised intention to establish a new form of accommodation. Although this often involved considerable change in the workplace, even this was not generally of the type described by Kochan *et al* (1986). Rather, the tendency has been to develop a system of collective bargaining within a context of mutual acceptance of corporate goals. Before discussing this in a little more detail, it should be noted how moves towards a new form of collaborative relationship were further encouraged by Government policy.

Ideological aspects of this policy are returned to later, here it need only be noted that since 1979 Britain has had a Government which has been out of sympathy with both the purpose and methods of trade union collective action. As both legislator and employer it sought to restrict the rights of trade unions and individual workers. The framework of collective labour law returned to its pre-1906 stage. This had particular significance given that the conventional justification for minimal individual protective legislation has been the existence of legal immunities in tort for trade unions. This erosion was indicative of a strategic intent to alter the relationship between British labour and capital. Further evidence for this emerged in the refusal of the British Government to ratify the "Social Chapter" of the Maastricht Treaty.

Yet, despite such hostility to trade unionism, Waddington concluded:

> It is unlikely, therefore, that legislative change caused the decline in membership during the 1980's. This is not to argue that legislation has had no influence, but to suggest that the structural and economic context of legislative enactment conditions its effect. (Waddington, 1992).

A greater consequence of the legislation has been in its impact upon the character of union behaviour. Re-definitions of what constituted a lawful trade dispute, and the imposition of financial penalties against union funds rather than individuals, substantially constrained the activities which unions felt able to support.

Aside from its legislative role, the Government was able to change other aspects of the union's institutional environment, symbolised in its rejection of a tripartite approach to the national economy. The high point for this had been in the 1960's and 1970's when national union leaders achieved a degree of involvement in economic and social policy which had been unsuccessfully sought by their predecessors in the late 1920's. However, the 1980's saw union leaders back on the sidelines, and by 1992 the announced disbandment of the NEDC formalised what had in effect been largely achieved. The demise in corporate-style involvement had greatest impact upon the TUC, for which it created a very specific crisis. For most unions the major direct consequence was in making the maintenance of relations with employers increasingly important.

Meanwhile, several pieces of research confirm changes in patterns of workplace representation during the 1980's. Attracting particular interest have been claims concerning the emergence of a more "macho" style of management. Mackay (1986) reports results of a survey of fifty six establishments indicating forty three per cent of personnel managers felt that management's approach to employee relations was harder and more confident. This has occurred alongside an apparent interest in the use of quality circles and other techniques designed to alter the nature of collective bargaining rather than displace it.

Evidence also suggests an emergence of new forums for representation, as in the establishment of joint consultation committees, which one-third of managers interviewed in surveys conducted by the IRRU and UMIST reported as having been newly established or recently strengthened. While Mackay (1986) interpreted

this as a move to by-pass trade union organisation, Edwards (1985) was more qualified in his assessment of it as a "significant trend" rather than a "massive shift".

What is clear is that institutional support from employers continues to provide an important base for union organisation. This is illustrated in a comparative study of electronics factories which found the most important variable determining union membership to be the individual plant at which a worker was employed, with management at one being particularly supportive (Guest and Dewe, 1988). Employer support for unions has not shown a universal decline, although it may be that the role of employer behaviour may be greatest in newer workplaces (Waddington, 1992).

Undoubtedly there has been hostility to unions within the private service sector. At the same time, the conclusion of the 1984 Workplace Industrial Relations Survey should be noted:

> Generally speaking, these results do not indicate extensive attempts by unions to recruit in no-union establishments, given that our questions were about attempts within the previous five years (Millward and Stevens, 1986).

Similarly, in a study commissioned by USDAW the main reason given by part-time shop workers who were not in a union was that no-one had asked them to join. Most of these worked in non-union establishments (*Labour Research*, March 1989). Nevertheless, so far as unionised establishments are concerned, much of the evidence from the 1980's suggests most employers seemed prepared to accept a changed relationship with established unions. To this extent the institutional support they were willing to provide can be seen to have been a significant influence on the character of union organisation and behaviour. Even when a hostile employer, the Government, withdrew the bargaining machinery for teachers the

greatest impact may be judged to have been in its effect on the character rather than the level of school-teacher trade unionism.

Overall, neither employer or Government behaviour in themselves seem sufficient to explain the scale of union decline. Their influence would seem to have been as much in the style and character it took as in its density. The important issue for the present discussion is the relationship this has with sectoral and compositional changes in the workforce. How far have these fundamentally altered the potential for union activity within the workplace and beyond. This also can be approached by considering the consequences for collective organisation among workers *per se*, and the character and form which it takes.

The Sociological Context: understanding union character

As in the preceding discussion, it is important to look at divergencies within aggregate trends. It should also be noted that even after the considerable fall in union membershipit remains at a significant level. Almost ten million people in this country remain trade union members, a figure at least five times greater than the membership of the Anglican Church, a body which has enjoyed a substantially different relationship with the state. Indeed, in the early 1980's the ideological hostility of the Government to the principle of trade unionism was not generally so evident as it later became. Wedderburn discusses its progression from the time when the then Employment Minister introduced the 1979 Employment Bill by stating:

> The law should always give full recognition to the inherent weakness of the individual worker *vis-à-vis* his employer, to the need for him to be organised in a union and to the need for his union to have such exceptional liberties as may be necessary to redress the balance. (quoted in Wedderburn, 1989, p3).

The ideological source of the subsequent shift, which Wedderburn attributes to the influence of Hayek, is less important here than whether or not it corresponded with a wider change in popular cultural perceptions about trade unions. Such a claim receives little support from opinion poll evidence which suggests that unions became more popular than they had been for many years. This may well reflect union weakness rather than strength (Edwards and Bain, 1988), but even so it does not suggest ideological success in challenging the basis of trade unionism. To this extent the TUC Special Review Body seemed justified to conclude from its own review of opinion poll evidence that, "Most people have a positive attitude towards the trade union Movement." (TUC, 1988).

Yet even though this may be true, it does not explain why so many have chosen not to join it. An important aspect of this has been the impact of occupational change, the real significance of which lies in its relationship with social identities. The link between sectoral change and unionisation is not automatic. As a review of European union experiences in the 1980's noted, "There are a number of instances where unionisation expanded rapidly while labour markets militated against union growth" (Visser, 1988, p143). The successful unionisation of private mail and fast food service workers in Lombardy offer such examples (Kane and Marsden, 1988). Historical experiences similarly demonstrate the dangers of assuming, as one writer said in the 1940's of white-collar workers, that certain groups of workers, "don't join unions". (Quoted in Nicholson *et al*, 1981).

It should also be noted that some of the historical examples used by Kelly (1988) to demonstrate that occupational changes need not necessarily impede union growth, involved workforces already in possession of a strong trade union tradition. This was not by any means universally true, but was the case, for example, for much of the new manufacturing industries the 1930's. Similarly, when Terry (1984) uses the example of the development of strong workplace organisation at

Fords in the face of management hostility, account must be taken of the previous trade union backgrounds of local activists and related features of local culture, as at Halewood (Beynon, 1973).

This style of trade unionism was highly "unionate", and it has been the one which has taken some of the hardest battering in the 1980's. In the case of strike activity, the average number of stoppages per year in the 1980's was less than half that of the 1970's, and by 1991 the number of working days lost was fewer than in any year since records began one hundred years ago (Bird, 1992). Interpretations of union development in the 1980's must therefore confront the question as to whether the character of trade unionism constructed in the industrial manual sector continues to provide a sufficient indicator against which to judge developments.

Not all organisations have suffered decline. Nor can sectoral change alone account for the 78.4% growth in membership recorded by the Royal College of Nursing between 1979 and 1990, or the boosting of the membership of the Assistant Master and Mistresses Association to 138,571 by 1990 (Certification Officer, 1991). A proportion of this growth, but by no means all, has been achieved at the expense of traditionally more "unionate" organisations. Nevertheless, it does not suggest an abandonment of collective organisation.

Nor should the figures be taken to imply a wholesale rejection of industrial militancy. The public services in the 1980's provided the setting for some of the major disputes of the decade. Albeit in the context of an all-time low in strike activity, one-half of working days lost through stoppages of work in 1991 were in public administration (Bird, 1992). What it suggests is that divergent trends have reflected alternative forms of collective representation rather than substitutes for it. The continued need for collective organisation is founded upon the inherent nature of the employment relationship. The following considers ways in which this relationship can give rise to an attachment to trade unionism, beginning with the notion of "instrumentality".

In an early piece of work, claims that the more individualistic orientations of white-collar workers provided the explanation for lower levels of union membership was questioned by Cook *et al* (1975) who suggested that differences were more of a practical than ideological character. That interpretation appeared to be largely born out by the subsequent recruitment of white-collar worker. The view that instrumental rationality provides the basis for union membership decisions is implied in the conclusion drawn by Bassett (1989) that union success in meeting instrumental demands of members is of over-riding importance. If this is so then wider attitudes towards the role of unions in society might be regarded as far less important.

Indeed, there appears to be no necessary link between general perceptions of unions and individual membership decisions. This is shown in the apparent paradox that the increased popularity of unions correlates with reductions in strike activity and lower inflation (Edwards and Bain, 1988), whereas membership growth has been associated with periods of increase in these two variables (Bain and Elsheikh, 1976). American research tends to confirm that worker's perceptions of what unions achieve in their own workplace has a far more important influence on membership decisions than do the general image of unions in society held by individuals (Kochan, 1980).

This type of research also provides an opportunity to explore some of the issues which seem to be given priority in these decisions. Reviews of the literature suggest that union membership is associated with levels of job dissatisfaction, together with a perception that unions are instrumental in improving terms of employment (Nicholson *et al*, 1981; and Klandermans, 1986). These factors were found to be better predictors of union certification voting behaviour than personal characteristics of the type analysed by Bain and Elias (1985). Similarly, Guest and Dewe (1988) ranked factors influencing union membership in their study of

selected electronics factories in the following order; employer support, the extent to which unions were seen as representing workers interests better than anyone else, and worker's perceptions of union success at the plant. Conversely, a union sponsored survey of ex-members in Holland found that among those who were still employed, the most common reason for leaving was dissatisfaction with services provided rather than hostility to unions in general (Klandermans, 1986).

The implications of such findings has led a number of unions to use surveys as a means of identifying preferences by members and non-members. However, a difficulty arises in the notion of instrumentality in terms of what is implied about the nature of rationality involved. Hyman (1977) has pointed to the difficulties in applying rationality to strike activity, and a similar point could be made in relation to participation in collective organisation more generally. If someone is asked for an explanation as to why they joined a union they are unlikely to offer an "irrational" reason.

In his review of the American literature on union recruitment, Klandermans (1986) criticised many of the studies on the grounds of inadequate theory and method, arguing a need to give greater emphasis to factors such as social pressure. It is not necessary to deny any role for "instrumental" factors to question their location within a neo-classical model of human action which ignores the social circumstances of individual subjectivity. The notion of "union commitment" must be considered within a broader social context than is implied in a purely instrumental approach. This encompasses influences derived from pre-workplace experiences as well as within the workplace itself. The dynamic qualities of attitudes does not mean they are constantly changing, but that this can occur within particular constellations of circumstances.

This suggests not so much a waxing and waning of union fortunes as an automatic reflection of the business cycle, nor a widespread rejection of trade union values, but rather a continually changing environment to which collective labour

organisation must adjust. What shape might union character then take in order to respond to these changing circumstances?

A starting point is to note social survey evidence which suggests members may rate unions in their own workplace more favourably than they do unions in general (Harrison, 1984). However, in their study of electronics plants, Guest and Dewe (1988) found almost fifty per cent of union members, and over two-thirds of non-members, describing their own unions as either "unsuccessful" or "not very successful" in representing workers interests. Over fifty eight per cent of all workers, and this included nearly one-third of union members, felt there were no issues for which their best representative was their union. The significance of this lay in the authors conclusion that this may reflect the fact that worker's concerns extend beyond the terms and conditions of employment:

> There is evidence to show that dissatisfaction with work is associated with union membership but it exerts only a minor influence. . . it is dissatisfaction with involvement rather than with the terms and conditions of employment that is more important. . . unions might increase their appeal if they paid more attention to issues of involvement. (Guest and Dewe, 1988).

This statement has parallels with the "professional union" model for nursing advocated by Trevor Clay and which is described later. It implies that the basis for a manual-professional distinction may be less clear-cut than is sometimes suggested. If this were so, it would lend support to the thesis advanced by writers such as Touraine and Mallet in the 1960's on the prospect of alliances between professional and manual workers. Some evidence for this was apparent in the 1970's, but this has not been the case for much of the 1980's.

While encroaching managerial control over the labour process may be a general tendency, the way in which workers respond to this may not be so uniform. Goals concerning control over work become socially constructed in ways which

reflect differing sectoral and occupational identities. This in turn will shape the character of collective response to which it gives rise.

Writers such as Kelly (1988) have disputed the possibilities of "extended collective bargaining" within the constraints of capitalism, and to some extent this assessment receives support from what was noted earlier concerning managerial support for unions. Often this appears to have been continued on the basis of a more restrictive bargaining agenda. The potential conflict this can create, between maintaining employer support or member support, may underlie many of the difficulties faced by unions. The issue as to whether public services may retain some distinctiveness in this process can be left for now, instead one further consequence of Government policy upon union character needs to be noted.

If the Government proved unable to undermine collective organisation itself, they appeared to win a greater measure of support for challenges to allegedly undemocratic or bureaucratic procedures. An early clarion call of the Government, to "give the unions back to their members", provided an important ideological device for justifying several policy initiatives. Such claims were unfounded, as became evident when the legislation was used to obstruct membership ballots in the NUS dispute with Sealink, and prevent the TGWU giving support to decisions arrived at by its dock worker members through a ballot. Moreover, the Government received condemnation from the International Labour Organisation in withdrawing trade union membership rights at GCHQ.

Nevertheless, the rhetoric of policy on internal union processes seemed to achieve some resonance. Not always, though, did it produce the intended outcomes. Such was the case with the requirement for Political Fund ballots, held by many unions during the 1980's. Despite early polls suggesting only one or two unions would achieve majorities in favour of retaining a political fund, and these only narrowly, results were overwhelmingly in favour. This may reflect not a change of

opinion on the part of members but that they were confronted with a "real" decision in the ballots forcing them to adopt a more genuine opinion (Roiser and Little, 1986). Alternatively, the campaigns conducted by unions may have had a significant impact (Graham, 1986; Roiser and Little, 1986).

The possibility that unions can influence members' views in such a way is suggested by evidence from Germany. Prior to IG Metall's 1984 campaign for a 35 hour week a membership survey on attitudes towards working time indicated that just 5.3% of the membership supported a reduction in hours. Other information it provided facilitated a campaign which assisted in achieving, in some of the ballots, over 80% support for strike action (Hartmann and Horstmann, 1987). Two issues arise from this. Firstly, such a highly centralised strategy may be neither suited to British union traditions or to dealing with issues of control within the workplace. Secondly, it suggests the possibility of "tailoring" a campaign to meet particular concerns.

This was the case in political fund campaigns, particularly in relation to the Labour Party. A number of unions, including several adopting Political Funds for the first time, sought to emphasise that a political fund was required because the Government had changed the legal definition of "political activity", including within it many existing activities which would otherwise become unlawful to continue with. In contrast, other unions gave considerable weight to the role of their link with the Labour Party. Differences in campaigning tactics reflected what were perceived as being the more persuasive arguments for differing membership constituencies. The Political Fund ballots provided examples of ways in which unions responded differently to the same challenge, differences which reflected variant traditions of their members.

It was significant that it was in the area of internal decision-taking that the Government seemed to be having some impact upon the general character of union

organisation. This was particularly so given that this was potentially the area most under the direct control of unions themselves. Furthermore, the character of intra-union relations may have an important impact upon the degree of commitment held by members. From a case study of union organisation in a brewery, Spencer (1985) suggests that levels of membership satisfaction and commitment may be factors within the control of the union itself. Thirty eight out of forty four members interviewed described their union organisation as "very good" or "good", attributed by Spencer to the way stewards discussed issues with members at workplace branch meetings, encouraging an active and involved membership. He further suggests that the attitudes he found can be the product of recent workplace experiences.

Research from further afield has drawn similar conclusions. A comparative study of trade union members in Sweden and Iowa concluded that a significant influence on member's satisfaction with their unions is their perception of member-union relations and not only bargaining outcomes (Jarley *et al*, 1990). Of particular importance was the willingness on the part of the union to communicate information to members and listen to their views. That this may in turn encourage a higher level of membership involvement was suggested in a major study of one NALGO branch, in which it was noted, "it was particularly the democratic and accessible stewards who were associated with high levels of direct membership participation in the union." (Nicholson *et al*, 1981).

Two general conclusions emerge from this discussion. Firstly, compositional changes in the workforce are in themselves unlikely to provide the explanation for the decline of trade union membership. Their significance lies instead in their influence upon the changing, and possibly diverging, characters of collective organisation. Secondly, a more widespread experience has been that union organisation characterised by inadequate communication is likely to produce low levels of member commitment. How this is overcome may however reflect other differences.

Combined together these may create considerable difficulties for unions in seeking to reconcile pressures from members which may be very different to those to which they are subject from employers. It may well be that many of the debates in the 1980's as to whether union decline was a cyclical or secular trend missed a significant point, that the period was characterised by early attempts by unions to redefine themselves in ways which resolved these contradictions. It may be that an attempt to find a universally applicable strategy will prove illusory in the context of sectoral divergence. To begin to consider this the following outlines key features of alternative strategies being advocated by prominent union leaders.

Responses from the Unions

In the context of these divergencies and pressures, alternative strategies for union behaviour emerged during the 1980's. Their structural context, together with the sources of support they require, has laid a clear imprint upon them. The following discussion does not seek to analyse variant characteristics of union behaviour in the 1980's, instead the focus is on key statements made by national unions and their leaders and what these suggest about "strategic intent". The strategies need not be regarded as mutually exclusive, indeed the ambiguities they can reflect forms an important theme for the case study. A basic format for classifying alternatives is suggested in Table 2.2. Although it represents a simplification of variants within models, there is heuristic value at this stage in clarifying significant distinguishing features between them.

Table 2.2: A basic typology of union strategies

Sector	Strategy	Prominent sources of support
Private Manufacturing	Market unionism	Employers and members
Private services	Representational	State: employment legislation
Public services	Professionalising	State: occupational regulation
Public services	Campaigning	Members and service users

The "Market" or "Business" Union Strategy

This is the strategy which has attracted some of the greatest interest (Towers, 1987; McIlroy, 1988; Winchester, 1988; Waddington, 1988). Through its close connection with collective bargaining it represents a continuation of the historically dominant pattern of union behaviour in Britain. This has provided a clear express-

ion of, "The *raison d'etre* of every union . . . to exert influence on the terms and conditions operating in the labour market." (Muller-Jentsch, 1985). The strategy draws considerably upon experiences and traditions identified by Gavin Laird of the former AEU:

> The advances we have made were the result of collective effort. Paid holidays, sick pay schemes, occupational pensions, are the outcome not of benign government but of solid, determined, pragmatic trade union/employer negotiations (Laird, 1988).

The AEU and the EETPU were most closely associated with the model of market unionism, two unions which suffered some of the greatest membership losses during the 1980's. Their combined membership, omitting TASS, slumped from 1,753,174 in 1979 to 1,068,878 in 1990, a 39% decline (Certification Officer, 1991). That such a spectacularly unsuccessful strategy gained such influence reflects the basis of the organisations in the traditional heartlands of trade unionism.

In the context of the 1980's, the strategy was founded upon an increasing need for employer support, although even this can be seen as a continuation of an existing trend. "No strike agreements" can be interpreted as extensions to procedural agreements for the resolution of disputes entered into by unions for many years. The adoption of single union deals, although not widespread, reflects a greater willingness to accommodate to employer desires in order to achieve recognition and managerial support. In this way the strategy represents a shift along the continuum described by Muller-Jentsch (1985) towards the "incorporated" trade union.

Some aspects of market unionism are further centralising internal relations of power, encouraging a shift towards what Offe and Wiesenthal (1980) describe as a "monological" pattern of communication. On the basis of developing forms of representative democracy within the union's internal processes, the EETPU claimed, "More than any other union, our democratic structure ensures the representative

nature of our governing Executive Council" (EETPU, 1988). Representative democracy also can support a high degree of central control, as John Edmonds has pointed out:

> The AUEW holds to this system most firmly: leaders are elected and they do whatever they like until they come up for election again (Edmonds, 1985).

However, where traditions of strong workplace organisation exist, countervailing pressures may constrain such oligarchic tendencies. Equally, elements of centralisation and workplace organisation can combine, as in the campaign for reduced in working hours in the engineering industry. Divergencies within business unionism reflect differences between workers having traditions of organising relatively autonomously and those in "greenfield" sites for whom union recognition agreements may have preceded workforce recruitment. The Nissan Sunderland site, where the AEU achieved a recognition agreement but obtained relatively few members, illustrates the potential significance of this. The maintenance of employer support can have different outcomes depending upon the character of existing union organisation.

Market unionism continues a strategy which seeks union engagement in bargaining over the terms of productivity improvements rather than seeking to prevent them (Hyman and Elger, 1981). Data on rising union/non-union wage differentials in the 1970's appeared to lend some support to this approach, increasing, according to one estimate, from 7.5% in the 1970's to 11.1% in 1980-83 (Metcalf and Nicholl, 1985). More recent evidence suggests a declining differential, but the strategy is one which, in David Metcalf's words, concentrates upon the size rather than the distribution of the "industrial cake" (Metcalf, 1988). However, changed economic circumstances might again alter the basis for this, and future possibilities for a re-emergence of industrial militancy in sectors where the strategy has developed should not be ignored.

A potential for applying this strategy to public services is implicit in the argument advanced by the Labour MP, Derek Fatchett, that groups such as nurses and teachers may stand to benefit from the adoption of "pattern bargaining" techniques within a more fragmented system of pay determination (Fatchett, 1989). This would suggest the need for a more decentralised system of public service union organisation than has tended to be the case in the past, although it may neglect the extent to which management seek to control labour costs through the restructuring of labour. This possibility forms an important element of the "professionalising" strategy considered later.

At this point, it is important to note that the application of market unionism to public services is predicated upon capitalist employment relationships becoming increasingly generalised, with the locale of public services being regarded as secondary. Such a view has also been suggested in statements made on behalf of MSF appealing to smaller NHS unions, notably the HVA. These have stressed their private sector bargaining experience as equipping them with the expertise to operate in an increasingly commercially managed health service.

Pressures within public service organisations may be encouraging managers to act, "as if they were capitalists" (Crompton and Jones, 1984), and in turn encourage unions to respond similarly. The potential for this may be considerable, particularly as they start from a position of high membership levels and widespread recognition. What has been frequently lacking, however, has been a strong tradition of workplace organisation which might act as a counter-balance to the more bureaucratic features of the model. Nevertheless, if the distinctiveness of the public services is seen to be diminishing it may be regarded as an appropriate strategy. Before alternatives which tend to emphasise a continued distinctiveness are discussed, attention is given to a strategy which has been advanced most notably in the context of private services.

The Representational Strategy

Changing patterns of work created difficulties for extending market unionism as many employers outside of existing heartlands showed little willingness to respond to union overtures. A notable advocate of an alternative has been John Edmonds of the GMB, who has emphasised two important themes. The first has been a questioning of the centrality of work in the lives of many union members, particularly related to changes in the gender composition of the workforce. Secondly, he has expressed doubts about the ability of unions to deliver improvements to members through traditional collective bargaining. From this assessment flow two principal proposals: unions must become advocates as much as bargainers, and they must extend the range of services which are offered. While again these are not entirely new, they are located within a clearer identification of changing experiences of work.

A survey conducted for the GMB suggested that whereas men regarded union membership as a form of insurance, women wanted a union which would tackle problems they faced at work (*The Guardian*, 8th March 1989). In this, a correspondence can be noted with research evidence referred to in the previous section which identified involvement in a wider range of work issues as being of increasing importance. Here, however, it arises in a context where:

> Many of the new work groups will only have limited bargaining power . . . unions will need to develop an extensive network of local officials readily available to handle the many problems which will be passed on post haste by a multitude of local stewards (Edmonds, 1984).

The emphasis upon an advocacy role is closely linked to an extension in individual employment rights:

> Our best weapon is to be able to say: "join us, and we will ensure that the legal rights that we have helped win will be observed by your employer" (Edmonds, 1986).

Despite the significant differences with market unionism, both strategies can imply high degrees of leadership authority. In urging the retention of membership balloting for union executives, John Edmonds has argued, "their authority will increase, the room to manouvre will increase, and their right to make decisions will be seen to be fair." (Edmonds, 1985). Although elsewhere he has advocated initiatives such as open meetings and workplace discussion groups particularly aimed at involving more women members (Edmonds, 1988), the general emphasis is upon a system of representative democracy. As with the application of market unionism to new territories, this could give rise to a form of "quasi-participation" in which there is a separation of decision-making and participation processes characteristic of highly centralised and oligarchic unions (Muller-Jentsch, 1985).

The distinctiveness of the "representational" strategy is that it seeks to extend organised labour beyond its traditional basis. It has in common with some earlier approaches to work groups lacking strong collective traditions, an emphasis upon seeking a framework of legislative support. A difficulty it faced in the 1980's and since has been Government hostility to protection legislation for individual workers as well as for organised labour.

In the longer-term, the future for this strategy will be largely determined by the broader direction taken in the restructuring of labour by capital. Political, rather than solely industrial activity, will be crucial in this process. Unless the strategy can prove capable of recruitment in the absence of legislative or employer support, it faces considerable difficulties in the shorter term. Such have been the obstacles faced by a number of organisations in this sector, notably the banking unions.

One response to this has been a widening of the range of services provided to individual members. This has in fact been a feature of other strategies also, but it

has particular significance in the context of an inability to secure recognition from an employer. Some suggestions have been made for the provision of a lower subscription to provide an entitlement to non-bargaining services and advice. In many respects this would signify a return to a much older Friendly Society model, although in this role the unions would now be competing with a far wider range of alternatives.

In other ways, the strategy may have an unintended applicability to public services. Firstly, the character of much of public service trade unionism has long given a primary role to advocacy in the activities of union representatives (Watson, 1988). Secondly, one consequence of the fragmentation of health care services may be an increasingly blurred boundary between the public and private sectors. In the absence of effective workplace organisation, these influences may further encourage a representative rather than bargaining role.

Market unionism and representative strategies can each be seen as responses to changes in the relation between capital and labour which emerge differently in different contexts. As such they each relate in some way to aspects of public services. Attention now turns to union strategies which have tended to emphasise a continued distinctiveness of public services.

The "Professionalising" Strategy

The potential importance of the content of work has already been noted in connection with notions of union commitment. The issue has arisen in the advocacy by Trevor Clay, formerly of the Royal College of Nursing of a professional strategy for nursing staff, for which it is argued:

> Effective trade unions must be able to address the content and objectives of their members' work, not just the terms and conditions. (Clay, 1987, p143).

Two aspects of this strategy need to be noted. Firstly, it is accompanied by an explicit rejection of, "the historical concentrations on traditional industrial relations activity", (Clay, 1988). Instead, it is suggested that this be replaced by the adoption of methods used by pressure groups and voluntary organisations. Secondly, the proposal has arisen from within an organisation seeking to promote what can be described as an elitist occupational strategy. The professionalising strategy has been advanced in ways which emphasise its distinctiveness from manual worker trade unionism, particularly those characteristics most associated with "unionate" behaviour.

Worker organisation in the public services in the 1960's and 1970's had increasingly adopted the dominant model of industrial trade unionism; the process was never complete and was highly uneven but was evident in a new willingness to take industrial action. Carpenter (1982) however suggests that many nurses may have been encouraged to join the RCN in the late 1970's because of their rejection of industrial militancy. Given this apparent association between professionalising strategies and industrial militancy, it is worth briefly considering experiences of the latter during the 1980's.

In this period many of Britain's most significant industrial disputes occurred in the public services. These included the civil service in 1981, the health service in 1982, teachers in a long-running campaign in the mid-1980's, and ambulance staff and local authority white collar workers in 1989. Local authority manual workers were almost alone as a major occupational group in taking part in no national campaign of industrial action throughout the decade. By the late 1980's there was, however, evidence of a shift towards seeking public support through other means, as in the campaigns involving ambulance staff and teachers. This was far less true of the local authority white-collar worker's dispute, which in some respects can be regarded as having achieved greater success than was the case for several of the others.

Nevertheless, in recruitment terms, a more elitist appeal has proved highly successful for the RCN, which by 1990 had become the ninth largest trade union in the country. Similarly, the Assistant Master and Mistresses Association now ranks among the twenty largest (Certification Officer, 1991). Renewed attention to professional concerns has also been evident within some TUC affiliated unions. In 1988 COHSE created two "professional officer" posts within a newly established Professional Department, and a 1989 report of union structure considered the possibility of providing for differing occupational groups to have their own identity within the union. This was accompanied by a suggestion that more encouragement should be given to professional organisations to affiliate to COHSE (COHSE, 1989).

In discussing strategies designed to extend worker control over the labour process Kelly (1988) emphasised the power of capital to obstruct such attempts but in the context of services such as health care different considerations may apply. However, the manner in which the professionalising strategy has been advanced tends not to make it a generalisable one, particularly as it seeks to distance certain occupations from the rest of organised labour, rather than establish an alliance.

A less elitist approach which nevertheless maintains a focus upon issues of work content has been suggested in relation to social workers (Joyce *et al*, 1988). This argues the case for public service trade unions to give greater attention to the practice of those delivering services, with more emphasis upon finding new forms of local participation. By re-focusing attention on what many public service workers may hold in common, engagement in the production of use values, this approach has parallels with strategies designed to locate their activity within a broader network of social alliances.

The Campaigning Strategy

In a review of the state of British trade unions, Hyman (1989) refers to a need to link with other campaigns and social movements. The issue of the general application of this strategy, rejected by Kelly (1988), is returned to in the concluding chapter. Here the discussion is focused upon its relevance to public services. An emphasis upon the need for campaigning activities has arisen in several contexts, as when Winchester notes in discussing the strategy advanced by John Edmonds:

> A more extensive trade-union role in campaigns and community activities outside the workplace will also be required to offer the prospect of collective solutions to the problems of individually vulnerable workers and consumers (Winchester, 1988, p516).

Similarly, Ron Todd of the TGWU has argued, "Co-operation between unions and social action groups is what people in the community really need" (TGWU, 1988). A focus upon the mutual interests of trade unionists and local communities continues a long-standing, if minority, tradition within British trade unions, designed to secure improvement in the "conditions of labour". Recent examples of such alliances between trade unions and local communities have arisen around campaigns linking the defence of jobs and services.

One example of such a campaign is provided by a NUPE full time officer, who drew the conclusion in the early 1980's that health unions needed to change their strategy (Barber, 1982). However, in the wake of the Conservative's third consecutive election victory, Fryer noted:

> Trade unions in the public services have not been successful in winning public support in defence of public service jobs and services. The support must be won if the unions in the public services are to pass their most severe test yet (Fryer, 1989).

A continuing problem has been that only rarely have campaigns produced stable or permanent coalitions. One exception to this emerged in London in the

form of London Health Emergency, formed as a result of earlier individual campaigns. A principle objective was to draw together workers and users of local health services (Mackintosh and Wainwright, 1987). Support for its activities came from several unions, although there was a degree of suspicion among some national leaders about some of the political standpoints being taken. Such support was not translated into substantial resources, and the campaign's reliance upon GLC support made its future vulnerable.

Implications of placing greater emphasis upon campaigns and social alliances are suggested in a review of developments within Canadian public sector trade unions:

> There is now a consensus among public sector unions that widespread popular support for the preservation of public services must be developed as a logical adjunct to the bargaining process. This means spending substantial amounts of union resources on building alliances with consumers of public services, community organisations, parts of the women's movement and the churches (Calvert, 1990).

According to another writer, in Canada this has produced a shift towards "social unionism" and away from the "business union" model of the USA (Adams, 1990). Some evidence for a strategic orientation in this direction appears in a discussion document produced for the COHSE/NALGO/NUPE merger talks, which emphasise a need to develop connections between providers and users of services. Having parallels with the reassessment of work identities noted earlier in relation to the representational model, this is placed within a broader discussion of the character of public service trade unionism. Referring to the impact of social and economic change, the document suggests an:

> increasing complexity of people's social and political identities. To a great extent these are still occupational and collective, but increasingly they are individual and influenced by factors beyond work. Examples include the flourishing of new social movements, community groups and voluntary organisations.

> Whilst many of these have developed outside mainstream "politics" and trade unionism, they are deeply connected to the work and services provided by those who would be members of the New Union (p12-13) . . .
> The developments emphasise the need for a changed and wider conception of "politics" (p13) . . .
> If trade unionism emphasises mutual protection, looking after the less fortunate and promoting fairness and justice, this has always had a particular significance in public service provision (p15) . . .
> This New Union can be the key union in Britain, helping to shape policy and service delivery in a whole range of essential services (p42).
> (COHSE, NALGO, NUPE; 1990).

Past failures to effectively develop such an approach may be due to insufficient attention and resources, or as has been argued by Kelly, the consequence of its inherent limitation. Commenting on calls for the greater involvement by unions in wider social alliances, Kelly suggests:

> It is more plausible to argue that the mobilisation of wider, public support is in fact only a particular strategy appropriate in very specific circumstances. As an adjunct to industrial action by public sector unions, faced with an employer, ie the State, sensitive to public opinion, it may be of some use . . . (but) Even in the public sector, governments have a history of resisting the most well-organised and supported campaigns (Kelly, 1988, p119).

This statement illustrates two rather different forms which campaigning activity may take. The first represents an adjunct to bargaining objectives, examples of which could include the 1989 ambulance dispute, designed to place political pressure upon the Government. A second implies going beyond this, to develop new social alliances which involve workers and service users in the joint determination of objectives. In this they reflect differences of purpose and not solely those of methods.

In many respects, each of the four strategies discussed here reflect important ideological differences alongside those resulting from the impact of their structural context. This illustrates how collective organisations can give rise to a range of

strategic responses in reply to changing managerial challenges. These are returned to again in the case study material, although with a less explicit focus upon the representational strategy. This is on the grounds that it can be seen to rely for its full expression upon additional protective employment legislation. The main focus therefore will be upon possible sources of tension between bargaining, professionalising and campaigning strategies. For the present, having discussed characteristics of these alternative strategies, the following chapter provides a more detailed focus upon management and trade unionism in the National Health Service.

CHAPTER THREE

MANAGEMENT AND WORK ORGANISATION IN THE NHS

This chapter provides an organisational context for the discussion on NHS trade unions in Chapter Four, as well as giving some national background material for the local case study material. Although events are dealt with in a largely chronological order, this is done in a way to highlight certain themes. The most important of these is founded upon a recognition that it is necessary to incorporate both "social structure" and "social action" perspectives in understanding organisations. In particular, and in relation to the arguments developed in Chapter One, capitalist social relations provide an important but insufficient explanation for the way in which the NHS developed as a service and as an employer.

To sustain this argument it is necessary to go rather further back in time than the period which forms the main focus for this research. This enables the origins of what are described as the "first managerial challenge" to be traced, which in turn provides the context for examining the emergence of the "new managerialism" in the 1980's. Throughout the discussion, attention is given to the role of the state in relation to employment matters, particularly concerning pay and initiatives designed to raise efficiency and levels of labour productivity. The forms in which they came to be adopted within the NHS provide evidence on which to consider claims concerning the past or current distinctiveness of health care from the capitalist accumulation process. In turn this provides a basis for examining the development of NHS trade union organisation in the following chapter.

The First Managerial Challenge: the NHS before 1979

By the late 1970's several writers were claiming the emerging dominance of a new "managerialism", accompanied by increasing central control in the organisation of the NHS. Yet changes occurring in this period were arguably not so dramatic as might have then appeared. An important reason for this, it will be argued, was that the state had not gained as much influence over decision-taking as the new organisational structures might formally have implied. What had been achieved was a highly variable level of central control, an important factor in which was the equally variable levels of job control held by different groups of staff. To understand why this was so, and the consequences it had for the future, it is useful to trace back an early concern of the state, the cost of the health service to the Exchequer.

The impact of early financial restraint

In an appendix to the 1942 Beveridge Report, the Government Actuary had estimated that a national health service might cost around £170 million a year; yet in its first year of operation its actual costs were £402 million. Economies introduced at an early stage in the history of the NHS were in 1951 accompanied by the imposition of selected charges. Capital spending was also tightly constrained, even though the NHS had inherited many old buildings and equipment. In real terms, NHS capital spending was 12% less in 1952 than it had been two years earlier. Unsurprisingly, charges of financial profligacy were to be rejected by the Guillebaud Committee, established by the Government to enquire into resourcing for the NHS. In its report, published in 1956, the Committee concluded that:

> Any charge that there has been widespread extravagance in the National Health Service, whether in respect of the spending of money or the use of manpower, is not borne out by our evidence. (Guillebaud, 1956).

A research paper produced for the Committee, by the National Institute for Economic and Social Research, had shown that the proportion of national income spent on the NHS actually fell from 3.75% in 1949/50 to 3.25% in 1953/4. Relatively low spending continued throughout the decade, confirmed by data produced for the 1979 Royal Commission on the NHS. This showed that even though current expenditure rose in real terms by 20% from 1949 to 1959, this represented a slight fall as a percentage of Gross Domestic Product.

For the purpose of the current discussion, the more significant figure is that when the increased spending is deflated by NHS cost increases, rather than by the general price index, the rise in spending was 29%. During its early history, the "relative price effect" worked to the benefit rather than disadvantage of the NHS.

The main reasons for this are to be found in expenditure on pay, representing as it does such a large proportion of total costs. Gaining effective central control over pay had been an important Government objective from the outset. Unsurprisingly, it showed little desire to respond to criticisms from the Guillebaud Committee that terms and conditions of employment reached through national agreements were too inflexible. It was certainly unwilling to support their recommendations of a reduced role for central Government in pay determination, accompanied by a greater input from employing authorities. In fact, the Government had already acted to impose its authority upon employing authorities who appeared reluctant to accommodate to the centralism of Whitley. The 1950 Regional Hospital Board's Report drew attention to this in the inclusion of a report from the Comptroller and Auditor General, which noted:

> Rates of wages for hospital staffs are settled by Whitley machinery or by central negotiation . . . The Ministry's auditors have reported payments in excess of the approved scales and I noticed that some hospital authorities had not adjusted, or had declined to adjust, excessive salaries when requested by the Ministry to do so. (Regional Hospital Boards, 1950).

The Comptroller and Auditor General asked of the Ministry of Health what action it proposed to take against local hospital authorities who refused to comply. (It is worth noting that the largest occupational groups represented on these bodies were medical staff, capable of exercising considerable authority). The Ministry responded by making it clear that it, "hoped to persuade hospital boards to comply by administrative action but, as a number have not, the question of making regulations is under consideration".

The inference can be drawn that many local hospital authorities continued to hold out, as the Minister subsequently issued the 1951 NHS (Remuneration and Conditions of Service) Regulations. These, for the first time, stipulated that pay to NHS staff should, "be neither more nor less than the remuneration so approved." Pay was to be tightly constrained for most staff groups, including doctors, throughout the 1950's. Salaries of NHS administrative staff fell in real terms by twenty per cent (Spoor, 1967).

This early example of Government pay restraint will itself have had a direct impact upon cost increases within the service. More than this, there is evidence to suggest that it contributed towards staff shortages among certain groups, a frequent response to which was the recruitment of less qualified staff. Such substitution by cheaper staff formed a further important element in the containment of costs by the NHS throughout its early years. This can be illustrated by considering the situation in the psychiatric hospitals.

These hospitals represented a much larger call upon NHS funds than their patient numbers implied. In 1949, while accounting for only 2.6% of all patient discharges, psychiatric hospitals contained 42% of all NHS beds, employing 21.5% of all nursing staff, and 31.8% of Registered Nurses. Lack of adequate funding led in 1952 to the Chairmen of the Regional Hospital Boards bluntly describing the situa-

tion to the Ministry of Health, "What we need is more money, more buildings, more steel and more staff - none of which seems likely to be available". (quoted in Webster, 1988).

In that same year, nearly three thousand psychiatric beds were closed as a consequence of the shortage in nursing staff. By 1956, Cabinet minutes record observations by a civil servant that conditions in many mental hospitals were, "a disgrace" (Webster, 1988). Yet in 1958/59 the average costs per in-patient week in psychiatric hospitals were still less than one-third of those in non-teaching acute hospitals. A factor in this continued low spending had been that the problem of staff shortages was being dealt with through substitution.

One initiative for this apparently came from the Nursing Standing Advisory Committee, which urged a greater use of Enrolled Nurses. This proposal met considerable opposition from COHSE and others who described it as "dilution". But although the opposition to enrolled nurses was successful it did not create extra recruitment for Registered Nurses. Between 1949 and 1959 the numbers of psychiatric nursing staff rose by nearly eleven thousand, an increase of 34%, but nearly three-quarters of these were unqualified staff. The proportion of Registered Nurses in the total psychiatric nursing workforce, which had already fallen dramatically from around 53% in the 1930's (according to the Athlone Report), to 32% in 1949, was just 25% by 1959 (Department of Health Annual Reports).

In contrast, the proportion of unqualified staff, which the Mental Health Standing Advisory Committee had argued should be no more than 20% of all nursing staff (Webster, 1988), had risen to nearly 43%. Survey data for the period 1949 to 1956 also indicates that most of the newly recruited unqualified nursing staff were women (Webster, 1988). In the period before equal pay, as a high proportion of the qualified staff had been male this would have further reduced pay costs.

Given the strength at this time of COHSE within psychiatric hospitals, their inability to prevent this substitution must in part be accounted for by the character

of what they were seeking to defend, the status of the Registered Mental Nurse (RMN). A variety of evidence suggests that this status provides a good example of ways in which definitions of skill come to be socially constructed. That three years was required for their training may not have been always reflected in the "objective" skills which many of them possessed. Certainly their levels of academic attainment were lower than for other nurses: the Athlone Report indicated that the proportion of Registered Nurses in 1937 who had undergone elementary school education only was 25% in the voluntary sector, 71% in the municipal sector, and 92% in the mental hospitals (Abel-Smith, 1961).

From the immediate post-war years several accounts exist to suggest a low standard of training for RMN's. These include the example of a student RMN who spent three years working in the hospital gardens to find himself qualified to take charge of a ward (Carpenter, 1988). In 1953 the Oxford Area Nurse Training Committee observed that, "student nurse training in the majority of mental hospitals had been merely a token affair." (quoted in White, 1985).

If the pressures for labour substitution came from the impact of central financial control, opportunities for it were created by the nature of the skill which the unions were seeking to defend. The situation was rather different in the general hospitals. Here, between 1949 and 1959, the numbers of nursing and midwifery staff rose by 39%, an overall figure not very different to that in the psychiatric sector. The proportion of unqualified staff which this included was however noticeably less, rising from 15% to 18% of the total. At the same time, the proportion of registered nurses also rose, from 27.4% to 31.2% (Department of Health Annual Reports). Some of this difference is attributable to a greater use of part-time staff in general hospitals; survey data from the period 1949-56 indicates that of a total increase of 12,500 part-time nursing staff, over 82% was in the non-psychiatric sector (Webster, 1988). Even so, the numbers of full-time Registered Nurses also continued to grow in the general hospitals.

However, two underlying processes were occurring which were to have an impact upon staffing in this sector. The first of these arose from the non-reintroduction of educational entry requirements for nurse training which had been removed during the war years. White (1985) has argued that the General Nursing Council (GNC) acted as an agency for Government recruitment policy in this period, participating in the deskilling of nurses. She quotes from a 1957 report of the South East Metropolitan Area Nurse Training Committee, which indicated that the work pattern of student nurses depended more on the number of ward domestics than on their training needs. White argues that the consequence of the open entry system was that it brought in an emphasis on the "practical" nature of nursing, with any interest in an academic or theoretical basis being actively discouraged.

The second aspect related to the introduction of Enrolled Nurses into general hospitals. While their numbers had not yet reached a significant proportion of total staff, patterns for the future were beginning to be shaped in rising recruitment for pupil nurse training. This similarly appeared to emphasise the practical character of nursing work. The rising proportion of unqualified staff in the psychiatric hospitals, together with the "open entry" policy in the general hospitals, each contributed towards constraining costs. With such a large proportion of the total staff then working in psychiatric hospitals, savings in this sector must be identified as having made a substantial contribution to limiting the aggregate NHS pay bill. In addition, these changes were beginning to reshape the composition of the nursing workforce itself.

Meanwhile, the "productivity" of staff increased as the number of patients being treated was rising. During the 1950's the number of in-patient discharges and deaths rose by 35.7%, almost double the rate of increase in the number of nursing staff of 18.2% (Department of Health Annual Reports). Patient throughput in psychiatric hospitals rose particularly dramatically. Between 1949 and 1959 there

was a 93% rise in the number of psychiatric discharges, attributable mainly to the introduction of chlorpromazine in 1952 and other drugs soon after.

The extent to which the "drugs revolution" shaped the direction being taken reflected above all the dominance of the medical profession. One prominent psychiatrist described the new drugs as providing a means for meeting, "the urgent need to bring psychiatric treatment back again into line with general medicine." (Sargant, 1967, p200). Other therapeutic techniques had been advanced; the replacement of the asylums by smaller hostels had been discussed in 1949, and experiments with "therapeutic communities" were in progress in the early 1950's. The first, however, required more capital, and the second needed far more staff. Extending the use of drugs within existing institutions, while being clinically led by doctors, proved cost-effective and to that extent met the demands being placed upon the service by the Treasury.

There was a less spectacular increase in patient throughput in the general hospitals, rising by one-third from 1949 to 1959 (Department of Health Annual Reports). This was due to falling average lengths of stay which were accompanied by a shift from longer stay medicine to surgery. To some extent this can also be attributed to changes in clinical methods and technique: again doctors were able to determine its direction because of their ideological and organisational influence. Beyond this was the influence of social changes, and corresponding reductions in mass diseases of earlier eras, such as tuberculosis.

During the 1950's, the Government was able to control costs; only in the case of adherence to national pay agreements does it appear to have found it necessary to directly and explicitly control action from the centre. The rest it was able to achieve indirectly and, most importantly, within the existing relations of power in the health service. Early indications of change in this situation began to emerge by the 1960's

New attention to efficiency in the 1960's

Numbers of patients being treated continued to grow throughout the 1960's, with the figures for deaths and discharges from hospitals in England rising by one-third, from 3.78 million in 1959 to 5.0 million in 1969 (Department of Health Annual Reports). The most significant factor in this was a continuing decline in average length of hospital stay. Spending on the NHS continued to increase, rising in real terms by 59%, but unlike the situation in the 1950's this now began to represent a growing proportion of the Gross Domestic Product. By 1966 NHS spending accounted for 4.3% of GNP (Royal Commission, 1979).

From the available data, the underlying problem appears to have been that the "relative price effect" was no longer working to the advantage of the NHS. Costs within in it were beginning to rise faster than in the economy as a whole. The consequence was that when the rising expenditure is deflated by an NHS price index the real increase, in volume terms, was 29.9%.

Although this is virtually identical to the increased spending in volume terms during the 1950's, it now involved a much bigger claim on Exchequer funds. The difference between the two decades was thus the cost imposed on the Treasury and not the real volume of resources available within the NHS. This had particular implications as it coincided with early indications of the a slackening in post-war economic growth. As a result, the state began to play a new role in examining efficiency and productivity within the health care sector.

The first indications of this can be traced to the establishment of a committee on hospital efficiency in 1959. This was followed by a plethora of "hospital efficiency studies", expenditure on which rose considerably, from £18,000 in 1963/4 to £250,000 in 1966/7 (Klein, 1983). The period has been described as one dominated by the, "politics of technocratic change", in which an, "ideology of

efficiency" gained dominance (Klein, 1973). In this process several writers have applied Alford's model of structured interest groups, with it being characterised as one in which challenges to dominant "professional monopolists" were coming from "corporate rationalisers" (Alford, 1975).

Although there is evidence to support such an assessment, as in one historical account of Leeds Regional Hospital Board between from 1948 and 1974 (Ham 1981), the impact of this process should not be over-stated. The biggest challenge at this time was being made to groups of staff such as ancillary workers and nurses, rather than to doctors. It was a challenge, moreover, having its origins above all in state involvement designed to raise levels of efficiency (Carpenter, 1977; Manson, 1979). One consequence of this was evident in early moves towards a greater degree of central directive (Navarro, 1978). Staff groups which were weakest within the "matrix of social power" (Offe, 1984), were to be most directly affected by the emerging adoption of new managerial systems within this context.

The impact which "managerialism", founded upon models of rational decision-making, had upon the NHS is described by Haywood and Alaszewski (1980):

> The traditional view of health care as outside normal economic and managerial relations was accordingly replaced by a managerial perspective, based on models derived from industrial organisations. (Haywood and Alaszewski, 1980, p33).

The "injection of capitalist rationality" is described by Fryer *et al* (1978), pointing to 1960's reports on ancillary staff from the National Board for Prices and Incomes, and on nursing staff from the Salmon Committee, which criticised the quality of existing management within the respective service. Further examples of incipient central control in the overall structure of health care include the 1962 Hospital Plan, in which local services were to be organised around large District

General Hospitals (DGH), and the introduction by the Ministry of Health norms for lengths of hospital stay (Manson, 1979, p37).

These, however, cannot be judged to represent a major challenge to medical dominance which, if anything, could be seen as being bolstered by the emphasis given to the new DGH's. What, however, becomes most apparent from this period is that the new emphasis upon efficiency and rationality did not produce the desired results in terms of financial savings. Two reasons may be identified as significant in this; firstly, an unintended consequence of earlier shifts towards a less qualified nursing workforce, and secondly, the limited extent to which managerial authority was encroaching upon doctors and choices of clinical technique.

On the first of these, staff numbers continued to rise during the 1960's. Nursing staff increased by 38%, similar to the proportionate increase in the preceding decade. However, continuing a trend which had begun to emerge earlier, some of the biggest expansion occurred among Enrolled Nurses. This continued to reflect the "practical" emphasis being given to nurses, as did the fact that the proportion of trainee nurses within the total nursing workforce fell from 31.9% in 1959 to 26.6% in 1969. Of this latter group, 28% were pupil nurses, training for enrolment rather than registration (Department of Health Annual Reports). The dilemma this created for funding arose from the fact that, not only were they replacing Registered Nurses, but the previously large numbers of very low paid student nurses were increasingly being replaced by not quite so low paid Enrolled Nurses.

Similarly, a traditional practice in many psychiatric hospitals, of patients assisting with ward routines became more difficult to sustain. Increasingly, they came to be replaced by ancillary staff. Again, though such staff were low paid (in 1966 male ancillary staff came 123rd in the 129 groups whose earnings were published by the Ministry of Labour; NBPI, 1971), they were nevertheless more expensive than the groups they were being used to replace. This inevitably undermined

the financial goals which labour substitution, and the new managerial attention to work organisation, were seeking to secure.

Beyond this, relatively little impact was being made upon the authority of doctors. One attempt during the decade, through the 'Cogwheel Report', sought to introduce more checks upon medical practice but, unlike the case for nursing and ancillary staff, doctors secured a large influence in its implementation. New clinical techniques were however beginning to emerge which were not subjected to the kind of scrutiny being directed towards other staff groups.

Increasing pressures in the 1970's

By the late 1960's the once-only impact of substituting high numbers of student nurses, and patient labour in psychiatric hospitals, had been felt upon rising costs. From this time, an important outcome for total labour costs increasingly became the internal composition of the paid labour force. While general trends that this took can be identified, and are discussed below, these concealed considerable local divergencies. Because of the importance these had for subsequent Government and managerial responses, attention must also be given to the character of such variations.

The task of restraining costs was seemingly made harder in the context of pay rises achieved by several staff groups in the early 1970's. Each of the two largest occupational categories, ancillary staff and nurses, saw considerable improvements in their relative pay. Average earnings for male ancillary workers rose from 81.2% of average male manual earnings in 1970, to 91.2% by 1975, and for women the comparable figures were 99.3% and 120.2% (ASC Trade Union Side, 1984). Some of these costs may have been offset; as a study of London hospitals for the period 1968-74 found, increases in relative pay during the early 1970's was a significant factor reducing levels of ancillary staff turnover (Williams *et al*, 1979). Nurses

achieved substantial pay increases as a result of the 1974 Halsbury award, one which since then has frequently been used as a bench-mark by union negotiators.

As then might be expected, NHS costs continued to rise. From 1969 to 1977 Exchequer spending on the NHS rose in real terms by 47.5%, continuing approximately the same annual average increase as in the 1960's, and by 1977 NHS spending had risen to 5.2% of GNP. However, two points on this need to be noted. Firstly, this was not solely a British phenomena; levels of increase were in fact generally greater elsewhere. For example, in France between 1966 and 1977, spending rose from 5.1% to 6.8% of GNP, in West Germany from 4.8% to 8.0% in 1975 (Abel-Smith, 1984), and in the USA from 6.1% in 1965 to 8.6% in 1975 (Pollitt, 1983). Even though British health care spending was low by international standards, by the mid-1970's it created particular difficulties for the state as a consequence of the deeper profitability crisis being experienced by British capitalism.

Secondly, and at first sight paradoxically, the increases in spending equated to an annual average increase in volume terms of 4.1%, compared to 3.3% in the 1960's (Royal Commission, 1979). In other words, despite the increases in pay achieved by several staff groups, the situation had again been reached in the early 1970's where costs within the NHS were rising less quickly than in the economy as a whole. A major factor in this must have been the continuing decline in the proportion of Registered Nurses, the proportion of which fell from 33.1% of the total nursing workforce in 1969 to 30.4% in 1977. Increasingly they were being replaced by a growth in unqualified nursing assistants, the proportion of whom rose from 21.5% to 26.9% in the same period (Dept. of Health Annual reports). Although the 1960's also saw the growth of new professional groups, in relative terms they represented a small proportion of the workforce. The general trend continued to be towards a less-qualified or unqualified workforce.

While these changes in the composition of the workforce helped to contain rising costs, new pressures arose from the fact that, for the first time in the history

of the NHS, there was a slowdown in the growth in patient throughput. Largely this can be attributable to developments in medical techniques which significantly increased the number of diagnostic tests and procedures for patients. For example, while the number of non-psychiatric discharges rose by less than 9% from 1969 to 1979, there was a 64% increase in the number of hospital pathology requests (Dept. of Health Annual reports). Again, this illustrates the continuing dominance of medicine upon the control over clinical techniques. Whatever the merits of the greater range of diagnostic procedures, one consequence was an apparent fall in productivity.

In this situation, centralising processes within the NHS continued. The 1974 reorganisation, frequently presented as representing a move towards service integration, has also been described as a major centralising project which strengthened, "primarily, the class dominance and, secondarily, the professional dominance of this system." (Navarro, 1978, p58).

Its centralising tendencies were evident in changes which occurred in proposals for the new structure. The Labour Government's first Green Paper in 1968 had proposed accountability being between Area Health Authorities and central Government, with the addition by the time of the second Green Paper, in 1970, of a Regional Health Council, having planning and advisory functions but no executive authority. Its role was considerably extended by the time of the Conservative Government's White Paper in 1972, which described an intention to create, "a clear line of responsibility for the whole NHS from the Secretary of State to the Regional Health Authorities and through them to the Area Health Authorities, with corresponding accountability from area to region to centre." (White Paper, 1972).

A further example of centralising processes came in the second half of the 1970's, in the form of new systems of funding allocation. These were primarily

designed to counter existing inequalities in the distribution of resources. Wide variations in regional funding had their origins in allocations being based upon historic costs, a consequence of which had been to continue pre-NHS disparities in funding. The Resource Allocation Working Party (RAWP) was established as a means of moving towards a system of funding based more closely upon current need. Other inequalities in resources reflected a long-standing bias in provision towards the acute hospital sector, and from 1976 central policy required Health Authorities to direct funds to services for the elderly and mentally ill, described as the "priority groups".

Because the RAWP formula was being applied in a period of public spending cuts it created considerably difficulties for those areas who were "losers", notably London. So far as the shifting of resources to the "priority groups" was concerned, Haywood and Alaszewski (1980) suggest that many local obstacles could be used to delay its implementation. This suggests some qualification may need to be made to Navarro's observation quoted above, relating to the nature of class dominance in the restructured health service.

Undoubtedly, the changes significantly increased business influence in Health Authorities, with doctors being replaced by company directors as the single largest occupational group among their membership. Nearly half of the Regional Chairmen, and one-third of Area Chairman, were from a business background (Navarro, 1978). The medical profession nevertheless secured continued influence, and veto, through its representation on the new District Management Teams.

While, personnel specialists emerged for the first time within the new structures, signalling a recognition of the new industrial relations issues arising at a local level, medical staff remained relatively unaffected by such developments. In the local "negotiation of order" their influence remained paramount. A consequence of this for the internal management of hospitals was described in a DHSS handbook of 1972:

> The management arrangements required for the NHS are different from those commonly used in other large organisations because the work is different (DHSS, 1972).

Despite significant moves towards the creation of a more centralised structure, evidence is available which suggests continuing local divergencies. These indicate that many issues continued to be determined locally, and in this reflected the combined influence of historic funding inequalities and current power relations. An example of this is staffing levels and mixes, illustrated in the data on staffing in four selected mental hospitals in the mid-1970's shown in Table 3.1.

Table 3.1: Staff/patient ratios per 100 resident patients in selected mental illness hospitals with over 200 beds, 1976

	Nurses		Domestic
	Qualified	Unqual.	service
ENGLAND	30.9	26.8	11.9
Mapperly (Trent RHA)	43.8	42.1	19.7
Moorhaven (SW RHA)	32.7	28.4	12.9
St Edwards, Leek (W Midlands RHA)	19.5	19.1	8.7

Source: DHSS (1976)

It is interesting to note that variations in staff/patient ratios appear broadly consistent across the work-groups. This suggests that while the Treasury had long secured control over pay levels, no such central authority existed over the structure of the workforce. Moves towards a more uniform level of staffing had been made, as with the NBPI Reports on ancillary staffing levels, but the impact of these had been relatively limited. In this context, the overall trends in workforce composition should be seen as the product of short-term responses to financial pressures and labour markets rather than necessarily reflecting strategic intent.

By the end of the 1970's, indications of further changes in state policy were being signalled. Widespread criticism of the structure of the NHS were reported by the 1979 Royal Commission on the NHS, with attention particularly directed towards its local organisation. Complaints of "consensus management" creating indecision and delay led to the Commission hinting at the possibility of a "Chief Executive" role, a solution previously considered and rejected for the NHS on the grounds that clinical autonomy made it inappropriate. This issue was not to be determined until the 1980's.

The Royal Commission also directed attention to the structure of the work-force and numbers and types of staff required, finding little in the way of universally accepted staffing levels and mixes. Difficulties this created for attempts to rationalise the process of manpower planning were noted by the Royal Commission:

> It is impossible with our present state of knowledge to say how many workers the NHS needs and of what type: roles are not always clearly defined, the level of training required may not always be clear, and the difficulty of establishing standards of quality . . . is reflected in the absence of generally accepted staffing standards. (Royal Commission, 1979).

These issues, the relationship between managerial control and clinical autonomy, and the structure of the workforce, were not then resolved by the "first wave" of managerialism in the NHS. The extent to which managerial control had encroached upon existing patterns of work remained relatively limited. The search for new local solutions to these problems was to have particular consequences in the context of an increasing commitment to the market as a mechanism for efficiency in the 1980's.

A "New Managerialism": 1979-91

The objectives of change since the late 1970's demonstrate considerable continuity with earlier periods, with issues such as pay determination, the structure of the workforce, and the goal of greater efficiency, being to the fore. The character it took was however conditioned by two important influences: increasing financial restraint and later a renewed ideological support for market solutions.

Following the agreement between the Labour Government and the International Monetary Fund in 1976 health spending by the late 1970's was projected to rise by just 1.8% a year, the lowest growth rate since 1948 (Navarro, 1978). Initially these cuts had the greatest impact upon capital spending, a relatively easy target as they had been in the 1950's. Despite continuing cutbacks under the Conservative Government expenditure continued to grow, rising to 6.0% of GNP in 1982 (Abel-Smith, 1984). By the later part of the decade this had fallen again, to 5.2% of GNP (Socialist Health Association, 1988).

This, together with demographic changes and advances in medical techniques, led the House of Commons Social Services Committee to calculate that by 1987/88 the NHS needed a further £1.9 billion to maintain the real level of funding of 1980/81. Additionally, spending on health care in Britain continued to remain at levels lower than in most comparable countries.

The problems this created for controlling costs on the one hand, and maintaining output on the other, are discussed below under the following five headings: pay determination, restructuring work, management control, privatisation, and competition. In many ways these policy issues were closely intertwined, but there is value in exploring them separately at this stage in order to clarify issues to be addressed within the case study.

Pay Determination

Alongside the desire to hold down public sector pay, the years since 1979 have been dominated by two sets of concerns relating to pay determination: the criteria to be used and the level at which it is dealt with. The former included a brief experience of comparability, the extended use of pay review bodies, market-based arguments and a limited introduction of individual performance review. The latter has revolved around questions about more localised determination. These questions of "how" or "where" became increasingly inter-connected as proposals on pay determination advanced during the decade.

By 1979 the Labour Government's pay policy had assisted in the creation of several earnings anomalies among nursing and ancillary staff. For example, hourly rates for domestic staff, relatively low at £1.18, were in fact slightly higher than those of a nursing assistant, at £1.15, and represented 91% of the hourly rate for an Enrolled Nurse, and 79% of that of a staff nurse (IDS Reports). When differential enhancements are included, such as overtime and weekend rates, the gap could be further narrowed. One effect of this was to reduce the cost advantage of the greater employment of lower qualified staff evident in much of the 1960's and 1970's. In addition, NHS pay appeared not only low in absolute terms but unfair in its internal relativities.

An increasingly untenable policy culminated in the so-called "winter of discontent" in 1978-79, which brought into being the intended "standing" Commission on pay comparability. While both major political parties committed themselves in the 1979 election to accepting the Clegg recommendations, in the wake of the Conservative victory the Commission was quickly dispatched. By 1982 the operation of

a *de facto* pay policy in the public sector created a new wave of industrial unrest in the NHS.

The importance of this dispute, which as with the earlier one is discussed in Chapter Four, for the present discussion lies in its role in extending the coverage of pay review bodies (PRB's) to the majority of NHS staff. Largely this was as a result of the establishment of the PRB for Nurses and Midwives. As has been noted by the House of Commons Select Committee on Social Services, staff covered by PRB's have experienced higher pay increases than have those remaining within the purview of Whitley Councils.

Ancillary staff experienced a substantial fall in their real pay in both relative and absolute terms. Average gross weekly earnings for male ancillary staff had declined to 71.8% of those for all male manual workers in 1989, compared to 88% in 1980. While a hospital domestic (ASC Scale 1) saw her basic hourly rate rise between 1979 and 1990 by 120%, taking into account the 1980 reductions in working hours a nursing assistant experienced a 164% increase, and Enrolled Nurses and Staff Nurses saw rises of 219% and 220% respectively (IDS Reports). The Government's stated intention of linking the establishment of PRB's to "professional" groups refusing to engage in industrial action, though breached in reality, symbolised a desire to fragment the worforce in a way which undermined moves towards industrial militancy.

The Government sought to encourage the PRB's to take account of market factors, as in its evidence submitted for the Nursing and Midwives PRB second report which emphasised recruitment as the dominant criteria. In its response the PRB cautiously rejected this approach, arguing that several other factors, including comparability, needed to be included. Although this limited the scope for Government intervention in evaluation criteria, it was able to control the costs of awards by staging their implementation, or providing only partial funding for them from the centre.

An alternative system of pay determination for the NHS came with the arrival of general management. From the outset, the pay of General Managers was not negotiated through the Administrative and Clerical Whitley Council but determined directly by the Secretary of State. In September 1986 a DHSS circular instructed RHA's and DHA's to introduce performance pay for the approximately eight hundred general managers at regional, district and unit level from September 1987. Up to four per cent of their salary could be awarded each year, rising to a total of an additional twenty per cent over five years (*The Guardian*, 3rd September 1986).

In early 1988 the NHS Management Board decided that existing pay scales for a further 1,200 senior managers were, "no longer appropriate to these new posts", and contracts were offered which included the opportunity to earn performance related pay (PABB, 201). From September 1989 the maximum performance pay for General and senior Managers was increased from four to six per cent of their salaries, and the Department of Health considered proposals to extend the system of performance pay to a further seven thousand middle managers (PABB, 21st February 1989).

Managers meanwhile continued to have very little direct influence over the pay of other staff. Changes were implemented in the mid-1980's to increase the involvement of managers in the employer side of Whitley Councils, but these did not seek to alter the basic arrangements (Leopold and Beaumont, 1986). By the end of the decade a far more fundamental review of pay determination was being considered in reports produced by a range of bodies, from the Select Committee to the National Association of Health Authorities. Mostly these were cautious about moves towards more localised systems, with an implicit acknowledgement that the many difficulties encountered in arriving at an acceptable national system would not be removed simply by changing the level at which these were dealt with.

Of particular interest among the various proposals was one originally surfacing in a report by the National Association of Health Authorities and later

developed by a group of NHS managers themselves. This challenged the basis of distinctions based upon existing functional Whitley Councils and separate Pay Review Bodies, proposing in their place a single pay spine for all staff. However, as this proposal coincided with ones from the Government to allow for the establishment of "self-governing Trusts" the focus of much of the debate on pay determination now turned to question of "where" rather than "how".

Moves towards more localised systems of pay determination in the NHS have been highly constrained by the Treasury throughout its history. A change in this might create new opportunities for a more genuine local bargaining, but evidence that this is occurring is still limited. One question which the case study explores is whether changes in NHS organisation and management are giving rise to a renewed impetus for this to gather pace. An important context for this is the nature of changes simultaneously occurring in the composition of the workforce.

Restructuring the Workforce

The shape of the NHS workforce has changed substantially in the 1980's. Many factors have influenced this but particular consideration is given here to the impact of competitive tendering and associated policies on the ancillary workforce, and the restructuring of the nursing workforce. These changes are related to claims about moves towards a more segmented and flexible workforces, again to provide a context for some of the case study material.

The 1980's saw a marked departure from earlier trends towards a stable or declining proportion of Registered Nurses and increasing numbers of ancillary staff. Data on employment (measured in Whole Time Equivalents) of ancillary and nursing staff is shown in Table 3.2.

Table 3.2: Changes in the nursing and ancillary workforce, 1979-1989 (Whole Time Equivalents)

	1979	1989	% change
Registered Nurses	94,029	139,011	+ 47.8%
Enrolled Nurses	53,813	54,931	+ 2.1%
Other nursing staff	80,740	85,741	+ 6.2%
Ancillary staff	171,896	102,360	- 40.5%

Source: DHSS (1990)

Note: The figures in the table are not adjusted for changes in working hours. The reduction in the working week for nurses (from 40 to 37.5 hours) would require a 6.5% increase in WTE's to equate to the same staffing level. A one hour reduction in the working week of ancillary staff would equate to a 2.5% increase needed to stay the same.

Without disregarding the significance of competitive tendering for ancillary staff it is important to note that it can not be held responsible for all of the decline. Although reductions have been greatest among the groups subject to competitive tendering, they have not been restricted to these groups or the time period in which competitive tendering was implemented.

Hospital porters, for example, also experienced substantial job cuts, falling from 22,710 (WTE's) in 1984 to 17,205 in 1989, a decline of 24.2%. Total hospital ancillary numbers in England also fell by 20,000 WTE's from 1980-84, prior to the impact of competitive tendering (Dept. of Health Annual Reports). A notable feature was that 45% of this reduction occurred in the four London Regional Health Authorities and the London Post-Graduate Hospitals, those under most severe financial pressure as a result of the RAWP formula. Competitive tendering therefore provided an additional pressure upon a group already a target for job reductions.

In 1983 Health Authorities were instructed by the Government to invite tenders for catering, laundry and domestic services. Response from Health Authorities to a Government circular in 1980 requesting them to make greater use of pri-

vate contractors had been muted, with past dissatisfaction with standards obtained and concerns over loss of managerial control being expressed (*The Times*, 15th June 1980). A second circular in 1981 received a similar response, and it was not until after the 1982 dispute that the Government felt confident in imposing its policy more firmly. Greater emphasis was however placed on the opportunities to continue with "in-house" provision, as long as the competitive tendering process demonstrated this to be more cost-effective.

Job cuts among ancillary staff increased rapidly as a consequence of competitive tendering, as shown in Table 3.3.

Table 3.3: Ancillary staff in England (WTE's)

	1979	1984	1989	% change 84-89
Total	171,896	152,202	102,360	- 32.7%
of which:				
Catering	29,815	26,056	18,439	- 29.2%
Domestic	68,900	61,384	36,582	- 40.4%
Laundry	8,487	7,563	5,273	- 30.3%

Source: DHSS (1990)

Savings from competitive tendering have been estimated at £100 million, money which was retained by local Health Authorities. If these represent genuine savings, and thus improvements in labour productivity, it is important to recall the earlier figures on ancillary staff pay. Claims that joint collaboration in efficiency gains provide a basis for improvements in earnings are self-evidently not borne out in this case.

It can be argued that such neo-classical assumptions do not apply in a context where Government funding restrictions, coupled with public expectations about service delivery, do not allow for this type of distribution to take place. Bargaining is not taking place over the rate of profit but over "efficiency savings" and "cost improvements" which became essential for service maintenance.

It is also important to question the extent to which these savings reflected genuine productivity gains. In England during the ten years prior to the introduction of competitive tendering in 1983, the average number of available beds per WTE domestic staff (the measure adopted by the NBPI to measure productivity among that group) fell from 6.2 to 5.2, suggesting a fall in "productivity" of 16% (Department of Health Annual Reports). Following competitive tendering it is necessary to allow for the fact that more staff have been employed with private contractors; for example, from 1982 to 1987 the value of NHS external cleaning contracts rose from £9 million to £56 million.

This could represent employment levels of perhaps 2,000 and 9,000 respectively, which added to NHS staffing figures, suggests there were about 70,000 domestic staff in 1982, and about 50,000 five years later (Department of Health Annual Reports). Consequently, the ratio of average available beds to WTE domestic staff increased during this period from 4.9 to 6.0, close to the 1973 ratio. But any suggestion that this implies a "productivity" increase of about one-quarter must be severly qualified. Firstly, the introduction of more intense work practices, rather than a more efficient use of inputs, may have been occurring. Secondly, there is no guarantee that the same level of outputs has been maintained, with the strong possibility that that the process has been associated with cuts in service provision. Thirdly, while the 1970's increase in domestic staff occurred in a period when nursing staff were simultaneously losing many "non-nursing duties" there is some evidence to suggest that competitive tendering has transferred work back to nursing

staff (McLeod, 1985). A consequence may have been a divergence in trends, one towards an intensification of domestic work around routinised specifications, the other towards more flexible arrangements among nursing staff.

In another sense the example might be taken to suggest an element of convergence in the experiences of manual and professional groups, with each coming under increasing managerial control in ways which may be seen to undermine claims for distinctive professional opportunities. This might particularly be seen to be the case in the context of reassessments of existing divisions of labour in the NHS. Strong and Robinson (1988) describe the use by some managers of the term "tribalism" to describe fragmented "trades" within the health service, each seen as having their own histories and cultures. The word is in fact used by the NHS Training Authority, which suggested in a 1986 handbook that, "coping with this 'tribalism' of the Service presents some of the biggest challenges to management". A writer on the tasks facing general management has similarly claimed:

> An abiding problem in the NHS is that of demarcation boundaries between professions . . . The current occupational boundaries developed historically and seem to relate less and less to current work problems. (Edmonstone, 1988).

The writer goes on to argue, "There can be no professional 'no go' areas. It is managerial imperatives which are paramount." (Edmonstone, 1988). Given the nature of power relations within the health service, this was likely to present a particular challenge to the traditional hegemony of medical staff. But whether it might give rise to a more general reaction against encroaching managerial control has to be considered in the light of the possibility that it may produce variant outcomes for different groups of staff. This can be illustrated with reference to proposals for outpatient department nursing.

These were contained in a 1990 Department of Health Report which urged the replacement of qualified nurses with unqualified nurses to save costs. A later

report, by the Audit Commission in 1992, found one hospital to have followed this route had higher unit costs than another which had instead given new tasks, such as the counselling of patients, to the qualified staff. Technological developments in other fields has similarly provided scope for new work roles in areas, for example, where invasive surgery becomes less necessary.

Changes such as these might provide examples of what might be described as "flexible specialisation", but these have arisen alongside more negative experiences of contracting-out and temporary contracts. Although this has not created a clear bifurcation between a "core" and "peripheral" workforce, some elements of this can be seen. The possibility emerges of a small "elite" of more highly trained staff, such as nurses, becoming responsible for organising less trained work groups. While some staff may benefit others could be disadvantaged as their tasks become increasingly routinised and subject to control. This suggests no simple process of flexibility, and whether it is likely to create divergence or convergence between staff groups remains to be seen. Whichever is the case it directs attention to the processes by which managerial control is exercised.

Management Control

In understanding changes in systems of managerial control it is important to distinguish between Government rhetoric and reality. This particularly concerns claims that changes have resulted in a devolution of authority. Although elements of this are evident, the following discussion reviews experiences in the context of a continuing trend towards the centralisation of control.

Within months of the Conservative election victory in 1979, the Government was embroiled in a dispute over the degree of autonomy enjoyed by Area Health

Authorities. This arose from a decision by Lambeth, Southwark and Lewisham Health Authority to defy a Government order to implement spending cuts. The Secretary of State issued a Direction under s86 of the National Health Service Act 1977, transferring the functions of the Health Authority initially to the Regional Authority, and subsequently to five Commissioners.

The High Court later found the Secretary of State, "failed to exercise his discretion properly and the direction was vitiated by his failure." (*The Times* Law Report, 26th February 1980). Partly this was a technicality over the Secretary of State's use of the wrong section of the 1977 Act, but it was also implied that the AHA should have been given greater opportunity to explore other alternatives. On the day following the High Court decision the Secretary of State announced that the Government would not be appealing against the decision, but would introduce a clause in the forthcoming Health Services Bill to make compliance with cash limits a statutory obligation on Health Authorities (*The Times*, 27th February 1980).

By 1982 Health Authorities were instructed to impose "efficiency savings" capable of releasing 0.5% of budgets for other uses, later to be redesignated as "cost improvement programmes". Each Health Authority was required to include details of these in its annual programme. In 1984/85 cost improvements had generated savings of £105 million, a figure which had risen to £153 million in 1985/86. As with the previous efficiency savings, these were retained by the Health Authority. However, the TUC claimed that less than half of the £30 million efficiency savings achieved in the first year were attributable to improved efficiency, the remainder resulted from cutbacks in maintenance programmes and the like (TUC, 1984).

In the periodic appointment of RHA Chairmen in 1982, the opportunity was taken to ensure appointees were largely supportive of Government policy. This particularly affected those who had been seen as sympathetic to the health union's pay

campaign of that year, six of whom were not re-appointed. With the introduction of competitive tendering in the following year, Government powers were reiterated. The Minister of Health, Kenneth Clarke, wrote in October 1984 to RHA Chairmen:

> Some authorities may also have been influenced by the argument that the circular itself is not a binding direction in law. This is quite irrelevant and is not any sudden or unexpected discovery. . . . we look upon our health authorities as partners . . . However, we have always expected authorities to follow government policies and we are entitled to continue to do so. (*Health & Social Service Journal*, 8th November 1984).

The extent to which Government was capable of exerting pressure to obtain conformity to policy is illustrated in the case of Leeds Eastern Health Authority which reversed its opposition to competitive tendering when the Regional Health Authority threatened to withhold £1 million growth money and £900,000 of speciality funding (*Health Service Journal*, 15th May 1986). Similarly, the City and Hackney Health Authority reversed an early policy decision not to introduce competitive tendering following advice from their District General Manager which suggested:

> We are likely to be forced to do so either by the region influencing our money or by the Secretary of State ordering the health authority to do so. (*Health & Social Services Journal*, 7th March 1985).

Despite such evidence of increasing central directive, it remained the case that considerable scope for local variations in policy implementation remained. This was illustrated in the case of efficiency savings achieved by individual Health Authorities, on which the House of Commons Public Accounts Committee noted in 1985:

> For both years (ie 1984/5 and 1985/6) the target value of cost improvements contained in the individual programmes submitted by different authorities varied significantly . . . it seems likely that larger savings could be achieved if all authorities

> tackled the search for cost improvement with equal vigour. (National Audit Office, 1986).

During this period the Government had sought additional mechanisms through which to control local behaviour, in the establishment of two new boards following recommendations in the Griffiths Report. These were the NHS Supervisory Board, responsible for overall strategic policy, and the NHS Management Board, responsible for "controlling performance". The former, chaired by the Secretary of State for Social Services, included other departmental ministers, the Department's permanent secretary, and chief nursing and medical officers. The Management Board, while including DHSS officials, was strongly influenced by managers from outside: its first Chair was Victor Paige, the Director of Personnel was Len Peach (from the non-union IBM), and the Director of Finance was Ian Mills (from Price Waterhouse accountants).

This appeared to be a structure designed to distinguish between the strategic and the operational, but by 1986 tensions appeared. In June of that year Victor Paige resigned as Chair of the Management Board, complaining about Ministerial interference in his work. Len Peach was appointed acting Chair, but it was not until October that a permanent replacement was found. The possibility of further conflict between appointees and Government was removed by the appointment of the Health Minister, Tony Newton, with Roy Griffiths as Deputy Chair (*The Guardian*, 3rd October 1986).

Before long, critical voices were being raised within the NHS about the increasing centralisation of control. At a meeting of the fourteen Regional Chairs in December 1986, the Wessex Regional General Manager complained in a confidential paper that Government control of the Management Board, and increasing centralisation within the NHS, were threatening to erode the power of Health Authorities (*The Guardian*, 29th December 1986). By June 1987 the Director of the

National Association of Health Authorities was complaining that lines of communication were developing between General Managers, through regional managers to the NHS management Board, detracting from their accountability to local Health Authorities. He claimed General Managers were being seen as, "a more direct and efficient means for ensuring the implementation of central policy." (*The Guardian*, 18th June 1987).

While these criticisms were emphasising the threat to Health Authority powers, a different line was maintained by Victor Paige in a paper for the House of Commons Social Services Committee. In this he again criticised the degree of Government control, but argued instead for an independent corporate body to manage the NHS (*The Independent*, 4th June 1987). Although this was to be closer to what eventually emerged, changes were introduced in a way which ensured continuing control from senior politicians and civil servants.

Throughout this period further pressure was being applied to general management at a local level to operate on a more commercial basis. An example of this came in an announcement from the DHSS in 1987 that Health Authorities were required to raise funds through "income generation", expected to generate £20 million in 1988-89, rising to £37 million over three years. In April 1988 Health Authorities were instructed by the DHSS Income Generation Unit:

> To prepare action plans which will identify and pursue those business opportunities which will enable them to capitalise as quickly and profitably as possible on their local resources. (Quoted in Socialist Health Association, 1988).

By 1989 a highly centralised structure had within it an increasingly commercial ethos. At this time came a further change, designed to establish mechanisms for overseeing implementation of the White Paper, *Working for Patients*. A Policy Board, Chaired by the Secretary of State for Health and responsible for NHS strategy and objectives, replaced the Supervisory Board. A new NHS Management

Executive, responsible for operational matters, was also established in the place of the Management Board. Of particular interest is the fact that the composition of the Policy Board, responsible for strategic objectives, now also reflected business experience. The Department's Senior Nurse, who had sat on the Supervisory Board, was taken off (though this decision was subsequently reversed), and the Chief Medical Officer was given a seat in a personal capacity only. New members include Sir Graham Day (Chair of the Rover Group and Cadbury Schweppes, and former chief executive of British Shipbuilders), Sir Robert Scholey (Chair of British Steel) and Sir Kenneth Durham (Deputy Chair of British Aerospace). The involvement of business people was an extension of a process long evident; what is new was the strategic rather than purely operational role they were given.

General management at local level provided a vital piece in the "chain of command" from the Policy Board, through Regional and then District General Managers. No longer was the NHS to be regarded as different from other work organisations, as had still been the case in the early 1970's. Instead, as Roy Griffiths observed:

> We have been told that the NHS is different from business in management terms, not least because the NHS is not concerned with the profit motive and must be judged by wider social standards which cannot be measured. These differences can be greatly overstated. The clear similarities between NHS management and business management are much more important. (Griffiths, 1983).

Taken together, the cost improvement programmes, competitive tendering and income generation schemes were by 1989 producing annually recurring savings of at least £300 million. While representing a relatively small proportion of the total NHS budget, in the context of Government failure to match funding to increasing demand it represented a vital means of obtaining resources for growth at local level. The fact that it had taken ten years to arrive at this stage is itself indica-

tive of the difficulties the centre continued to experience in controlling local activity. By altering the "matrix of social power" (Offe, 1985) from the top, however, the Government had still not been able to guarantee absolute compliance. Managers were forced to confront existing identities and culture if they were to succeed in asserting their authority.

Commenting on this problem, one writer on general management has suggested that managers will need to secure local "alliances" in order to achieve their objectives (Thompson, 1987). While reference is made in this particular case to the public and users of health care, there has been little evidence of this having occurred. Nevertheless, the notion may remain a useful one in considering how managers seek to build support for their action at a local level, including the role of alliances within the service as well as outside of it.

Attempts to reshape the basis upon which the local negotiation of order occurs have arisen in the context of two further important elements of policy; privatisation and the injection of competition. Although closely linked, they are considered separately in order to clarify important points of difference. In discussing privatisation a broad definition is adopted, to include a range of attempts to alter the character of paid employment in health care, including an increasing reliance upon unpaid domestic labour as well as an extension to the role of the private sector.

Privatisation

Moves towards privatising services continued throughout the 1980's, from contracting out of services to the growth of private hospitals and nursing homes. Following the introduction of competitive tendering, although many services were won "in-house", contracts gained by the private sector were also considerable. The value of external contracts for catering, laundry and domestic services rose from

£16.7 million in 1983 to £110.6 million in 1990 (Department of Health, Annual Reports). Numbers of nursing staff employed in private hospitals and homes also rose, in the case of qualified staff from 30,000 to 36,000 in the single year of 1987 to 1988. Interestingly, the increase in the number of unqualified nursing assistants was even greater, rising from 33,000 to 43,000 (Mackay, 1989). The introduction of competitive tendering has already been discussed, here attention is given to the private hospital sector and the transfer of work from paid to unpaid labour.

Substantial Government encouragement has been given to the private sector, through for example the removal of development restrictions and the granting of tax relief to some private health insurance policy holders. One consequence has been that 17% of all elective (ie non-emergency) surgery is carried out in private hospitals (HMSO, 1989).Nevertheless, the rapid expansion of private health insurance during the early 1980's was not sustained. A factor in this was that the recruitment from social classes III and IV, more likely to experience worse health, was pushing up costs and hence premiums (Loney, 1986).

A notable aspect of the growth in acute private hospitals in the 1980's was the trend towards concentration of ownership, with the number of major operators being reduced to a small number of large companies. Coinciding with this, the Government actively encouraged joint schemes between Health Authorities and the private sector. However, the removal of pay bed restrictions, together with "income generation" requirements, also served to encourage Health Authorities to compete for private work themselves. Increasing amounts of private work were being performed within the NHS, with the income it generated rising by 19% in the year 1990-91 alone (*The Guardian*, 2nd April 1991).

Overall, developments in the acute hospital sector suggest not so much an outright privatisation, as an incremental blurring of boundaries between the public and private sector. This has served to constrain a larger scale growth in acute pri-

vate hospitals. A more direct encouragement to involve the private sector is evident in the care of patients discharged from hospitals under "care in the community" policies. There has been substantial growth in private nursing and residential homes, encouraged by their eligibility for DSS benefits. In turn this created its own financial pressures for the Government, intended to be resolved through proposals to direct new money through local social service departments. These will operate as "purchaser" rather than as direct "provider", with requirements imposed upon them to purchase predominantly from the private sector.

Care in the community policies have also involved privatisation from the public to the domestic sphere. Attempts to deal with problems arising from the past underfunding of services for the elderly, mentally ill and mentally handicapped imposed considerable financial demands on the NHS. DHSS data indicates that spending on hospitals for the mentally ill and mentally handicapped had risen from 10.2% of total hospital revenue expenditure in 1964/65 to 17.2% 1979/80 (Department of Health Annual reports), and in the context of increasing financial stringency these services attracted renewed attention as a potential source for savings.

One means for this was created in new opportunities to transfer work from paid to unpaid domestic labour in conjunction with moves away from large institutions. A survey conducted by the DHSS in 1980 had concluded, "the 'cost-effectiveness' of a package of community based services often depends greatly upon the presence of informal care.' (DHSS, 1981). The way in which costs could be transferred from the state to the family was illustrated in evidence given by the Disablement Income Group to the Social Services Select Committee. This suggested that a family caring for a mentally handicapped member might lose £1,600 in earnings a year, and add 8% to their weekly household spending plus about £3,500 required for capital expenditure during the mentally handicapped person's life (HMSO, 1984).

The consequence, as the Select Committee's report noted, was that, "the burden of care falls largely on the young person's mother and results in marked financial, physical and emotional costs". (HMSO, 1984). The extent to which responsibilities have been transferred from the public to the domestic sphere is evident in data from the 1985 General Household Survey, indicating there to be six million informal carers of elderly or disabled relatives and friends. Of these, almost 1.5 million spend twenty or more hours a week providing unpaid help, and over one-half of the total have not had a break of longer than one day.

Privatising work within the family has represented an essential element in the Government's programme to contain costs within the health sector while simultaneously encouraging the growth of the private sector. This has created twin pressures for managers in many ways comparable to those in the private sector more broadly. The first has been to identify "core" activities upon which to concentrate and those which can be divested, the second has been a greater awareness of comparative costs elsewhere. Each of these received further encouragement by policies designed to create a more competitive environment for health service organisations.

Markets and Competition

An increasing role for markets was identified towards the end of the decade against the background of a growing financial crisis. Widespread staff protests over funding shortages occurred in 1988, and in October of the same year a survey by the National Association of Health Authorities found that one-third of Authorities were contemplating cuts in services. Only the announcement of an extra £2.2 billion by the Secretary of State in November eased the pressure. Within the Government interest was turning to more fundamental reform, founded upon perceptions expressed in a document produced by the Centre for Policy Studies, "It is

not so much a lack of finance as the vastness of the organisation and the lack of any competition which is making the NHS squeak and groan".

Neo-classical assumptions underlying such claims suggest that competition provides an effective solution to problems of variable productivity. This has been identified as a long-standing issue within the NHS, one to which competitive tendering had earlier been directed. However, while competitive tendering has undoubtedly reduced costs, it is less clear whether this has involved a narrowing of the range which the theory would imply. Data from five selected hospital cleaning services indicates that despite overall reductions in costs, relative costs per square metre between hospitals remained virtually the same after tendering (Sheaff, 1986). This suggests that the prime incentive was the achievement of financial targets.

Renewed financial pressures provided the opportunity for advocates of greater competition to urge its extension. This included the American health economist, Alain Enthoven, who on a visit to Britain in 1985 suggested that the origins of wide variations in performance between different hospitals and districts lay in the absence of incentives for efficiency. His proposed "internal market" within the NHS was designed to provide such competitive incentives (Enthoven, 1986). At the time these proposals gained little support, and interestingly were rejected by the NHS Management Board in December 1986. The main advocate of Enthoven's ideas on the "internal market" was David Owen, who has described his unsuccessful attempts to persuade the Government to accept them (Owen, 1988). The initial disinterest in the proposal was reversed when it came to be embraced by the Cabinet sub-committee established to identify solutions for the NHS.

The system proposed in the 1989 White Paper involved a separation of the role of purchaser and provider in a "mixed economy" of health and social care. Purchasers for social care are social services department, while the purchasing of health care is split between District Health Authorities and GP fundholders.

Changes in provider arrangements included the provision for the establishment of "self-governing NHS trusts". The language used by Government Ministers to describe the degree of competition which is intended has at times changed, but however "managed" the market may be, it appears to represent a major break from previous systems.

Following in the wake of earlier changes to managerial systems and culture, the greater autonomy enjoyed by NHS Trusts might be expected to reinforce commercial pressures. Some indications have appeared that NHS Trusts may seek to enter the market for private health care, particularly as economies of scale within the NHS make comparative prices favourable in its direction. For example, charges for a private tonsillectomy and associated treatment are £480 at the Freeman NHS Trust in Newcastle, compared with £1,100 at a Nuffield Hospital (*The Guardian*, 18th May 1991).

An assessment that such examples of the commodification of health care within the NHS is removing any remaining distinctiveness it may possess must however be qualified. Firstly, it remains considerably restricted in scope for changing product lines in response to relative rates of profit. Secondly, unlike many production companies, it cannot simply transfer production elsewhere in search of cheaper labour or whatever. Thirdly, in the event of market failure, cessation of production remains as much subject to political factors as to economic ones.

This would imply that despite the sequence of changes reviewed in this chapter, a case remains for continuing to treat health care organisations differently in analytical terms. The extent of change should not be understated, but it is difficult to conclude that it has wholly transformed the nature of social relations within health care services. As one writer has observed:

> Within the NHS, while there will be systematic efforts to impose and extend "managerialism", it too will comprise complex and contradictory elements, and these will continue to be a

> source of internal conflict. Structures of control and management methods originating in the private sector will continue to be imposed on the NHS, but their implementation will be contentious and partial. (Flynn, 1992, p194).

In many respects, the centralising tendencies suggest that a strengthening of managerial control, within a more competitive market environment, have been largely designed to weaken both professional and trade union sources of control and influence. Implications this may have for local managerial behaviour, and the character of responses to which they give rise from unions and other organisations, are considered in more detail in the case study material. To provide a further context for this Chapter Four traces the development of trade unionism in the NHS.

CHAPTER FOUR

CHANGING PATTERNS OF NHS TRADE UNIONISM

At the time of the establishment of the NHS, trade unionism was relatively weak within it, particularly when compared with other parts of the public sector. The origins of this weakness lay in structural and ideological features of pre-NHS organisation which provided the basis for a contrasting array of staff organisations, reflecting both sectoral and occupational distinctions. Important in this were differing definitions of purpose.

The first part of this chapter explores elements of earlier traditions by comparing the influence of industrial models founded upon collective bargaining with those of "professionalising" models. The major content of the chapter is then used to explore aspects of NHS trade union organisation from 1948 to 1979. This is organised in two sections, dealing with the period of union decline, from 1948 to 1965, and union growth, from 1966 to 1979. The final part considers the impact of developments in the 1980's.

Pre-NHS Trade Unionism:
Industrial and Professionalising Strategies

An obvious focus for discussing the relationship between industrial and professional models is nursing, particularly in the experiences of the National Asylum Workers Union (NAWU) and the College of Nursing. These two organisations, based within psychiatric hospitals and general hospitals respectively, provide examples of very different traditions, one which could be described as unionate, the other as professionalising.

The heartland for pre-NHS health service trade unionism had been psychiatric nurses. It was among these staff that the National Asylum Workers Union (NAWU) had been established in 1910, gaining national recognition ten years later. It negotiated with the Mental Hospitals Association, although the national minimum rates were unevenly adopted, only gaining general observance by 1939 (TUC, 1981).

In the local authority hospitals, trade unions had experienced little success in recruiting nurses, and for them no national negotiating machinery existed until 1939. Some ancillary staff were covered through local authority agreements. Collective agreements were virtually unknown in the voluntary hospital sector where there were few union members (TUC, 1981).

Explanations which have been offered to account for the level of unionisation among psychiatric nurses have included the existence of a higher proportion of male staff, the stronger discipline held by matrons in other hospitals and a stronger association with professional rather than manual worker's attitudes in other hospitals (TUC, 1981). Added to this should be the role of occupational class itself.

Although the role of gender has often been referred to, its actual influence is questionable. To give two examples from areas near to that in which the case study was conducted; in a dispute at Exeter Asylum the majority of strikers were women, while male staff continued to work during a dispute at Bodmin Asylum (Carpenter, 1988). As Carpenter points out, a decline in the proportion of women members occurred as men with trade union backgrounds were recruited into psychiatric nursing in the 1930's, when it became the Mental Hospital and Institutional Workers Union. While this may have reinforced the predominance of the bargaining model, it should also be noted that this period coincided with the adoption of a more moderate approach by the union.

Very evident at this time were social class differences between entrants to psychiatric and general nursing. Some indication of this is provided in data on

educational qualifications of nurses collected for the Athlone Report of 1937, which showed that in 1929 only 17% of probationer nurses in voluntary hospitals had finished schooling at elementary level, compared to 94% of probationer mental nurses (Abel Smith, 1961).

If gender provides an inadequate basis for explaining the character or density of unionisation in mental nursing, there remain the explanations based on job control, particularly in the role of matrons, and on professional ideologies. The first of these would seem to correspond with Bosanquet's assessment that industrial relations in, "psychiatric hospitals have always been different", because their staff enjoyed a greater degree of job control than was the case for others (Bosanquet, 1982).

However, there may be a danger of inverting the causal relationship here. At the time of the formation of the NAWU, mental asylums were frequently run on dictatorial lines with power vested in the medical superintendent. Rule books detailed what staff could and could not do. One superintendent, for example, wrote just before the First World War that unions in psychiatric hospitals would be tantamount to "mutiny". Without disregarding the influence of other factors, a significant aspect seems to have been the rejection of a professionalising strategy by the founders of the NAWU for having failed them. The formation of the NAWU was itself prompted by dissatisfaction with the Asylum Workers Association (AWA), a professional organisation dominated by superintendents and senior nurses (Carpenter, 1988).

The turn towards bargaining for improved conditions of employment brought the new union into conflict with the existing power relations. Several early episodes of NAWU activity were directed towards challenging aspects of the dictatorial regimes within asylums. Many of these are described by Carpenter (1988): for example, seeking the abolition of fines for disciplinary offences (Cardiff, 1911),

opposition to a policy preventing female nurses from working on male wards (Hull, 1916) and a strike following the dismissal of the Branch Secretary for "insolence" to the Medical Superintendent (Exeter, 1919). This adoption of a more unionate identity corresponded with similar developments elsewhere in this period. The rejection of a professionalising strategy as a means of extending job control must be seen in the context of the class background of many psychiatric nurses.

As was noted above, that of general nurses in the voluntary hospitals was very different. Among this group the more prominent organisation, the College of Nursing, was established in 1916 having as its principal objectives the promotion of education and training of nurses, explicitly rejecting any comparison with a trade union. In 1926 the College opposed a Labour Party policy document on nursing principally because of a sentence which read:

> the only way in which nurses can deal effectively with their conditions, and exercise any sort of equality in bargaining power, is for the profession to be organized on Trade Union lines. (quoted in Abel-Smith, 1961, p132-33).

Opposition from the College was only defused following a suggestion by Beatrice Webb that the words, 'Trade Union' be replaced by, 'purely vocational'. Nor were their objections purely based upon the methods of trade union bargaining. The College also opposed legislative intervention, as in the case of a parliamentary bill presented by Fenner Brockway MP in 1930. This was intended to introduce a minimum wage and maximum hours for nurses. In its response, the College stated in its journal:

> As long as we take pride in being a 'profession' we must go to work by the voluntary method . . .Would doctors, artists, professors or university students call in the law to regulate their hours of study or service? Would they not rather evolve a code of conduct for themselves, and from within, as all professions have done before them? (quoted in Abel-Smith, 1961).

The significance of this statement lies in what it illustrates about the particular character of the professionalising strategy being adopted. This was seeking to emulate the experience of perceived "successful" professions. The founders of the NAWU rejected such a strategy for having failed them, whereas leaders of general nursing believed it to represent a viable and appropriate method.

It faced, however, two major problems. Firstly, it was seeking to identify itself with professions whose dominance was achieved in historically highly specific circumstances (Johnson, 1972). Secondly, although gender may not adequately explain the growth of trade unionism in psychiatric nursing, the dominance of women in general nursing further weakened its opportunities to assert itself as a profession. Instead, the gender-structuring of paid employment in health care tended to emphasise the "hand-maiden" role of nursing.

While the NAWU had secured several bargaining gains, the limited success achieved by the College had caused it to weaken its opposition to involvement in issues concerning pay and conditions by the 1930's. By the time of the establishment of the NHS, the RCN was able to secure a majority of the staff side seats on the Nurses and Midwives Whitley Council. The distinction it had earlier drawn between professional status and remuneration was being called into question, yet it remained as a source of influence over the character of collective organisation within the newly formed NHS.

The NAWU and the College had each constructed their definitions of purpose differently. This had reflected their contrasting class composition, and the occupational identities to which these gave rise. In turn these were sustained and reinforced through socialisation experiences within the workplace. Contrasting characters of the organisations mirrored those in occupational identities and the ideologies surrounding them. Instrumentally, the professionalising strategy proved less suited to the changing environment yet elements of its character remained.

Decline and Growth of NHS Trade Unionism: 1948-1979

Trade Union Weakness (1948-1965)

In the early years of the NHS, nursing trade unionism remained concentrated in the psychiatric hospitals. The largest organisation here was the Confederation of Health Service Employees (COHSE), formed through a merger of the Mental Hospital Workers Union (MHWU; formerly the NAWU) and the Poor Law Workers Association (PLWA). The latter, the smaller partner, provided a membership base within the ex-municipal hospital sector where local authority unions, including NUPE and NALGO, were also organising. Trade unionism had still made few inroads into what had previously been the voluntary hospital sector.

Significantly, despite the extension of collective bargaining machinery as a result of the establishment of the NHS, overall the period was one of decline in aggregate union membership and density. To a considerable extent this may have been a result of the fact that the most rapid employment growth was occurring in the previously least organised sectors. In addition, the highly centralised industrial relations machinery left little scope for local involvement. This structure had developed in the period immediately prior to and during the Second World War and largely formed the basis for the new Whitley Councils. The range of issues subject to central determination is evident in the fact that of an average of 120 Ministry circulars sent out each year in the 1950's, one-half related to Whitley Council matters (Klein, 1983).

One issue upon which the staff organisations had been able to achieve some influence concerned the role of the General Whitley Council. They ensured the rejection of Ministry proposals to grant powers for determining all pay and condi-

tions issues to this Council, instead this was to be under the control of separate functional Councils (TUC, 1981). This suggests that individual occupational identities were being rigorously defended.

Given the extension of institutional support in this period, why did unions experience such difficulties in recruiting among the newly expanding sections of the workforce? One factor is likely to have been the very limited extent to which institutional incorporation had developed locally. Even where central directive was designed to encourage greater local consultation, the impact appears to have been limited. One circular, issued to Hospital Management Committees in 1950, urged the establishment of local Joint Consultation Committees, but these enjoyed little apparent success (Miles and Smith, 1969). This is attributed to lack of commitment among hospital managers, lack of training for representatives, insufficient central support, and above all, the refusal of doctors to participate. JCC's were mentioned for the last time in a Ministry circular in 1952 (Dimmock, 1977).

Allied to this, Carpenter (1988) suggests that COHSE's difficulties in making inroads into general nursing were significantly affected by the RCN influence in training schools. COHSE's ability to recruit among general nurses only gathered pace once it attracted members in more senior grades. Furthermore, COHSE did not attempt any significant recruitment in general hospitals in the 1950's, at one stage seeking separate Whitley Council arrangements for psychiatric hospitals (Carpenter, 1988). This suggests the significance, not merely of institutional support for bargaining purposes, but of a more general incorporation into the prevailing organisational culture.

Remaining with the example of nursing trade unionism, this point can be illustrated by considering contrasting responses by COHSE and the RCN to the problems of staff shortages described in the previous chapter. Firstly, it is worth noting that minutes of the General Nursing Council from the 1940's record opposi-

tion from the nursing associations to the "open entry" system to aid recruitment, but support from both employers and unions (White, 1985). This illustrates the extent to which different definitions of purpose influenced the character of responses.

Similarly, in their responses to nursing staff shortages in the 1950's, COHSE sought a solution through improvements in earnings, while the RCN showed greater concern with issues concerning the content and delivery of nursing work. Neither, strategy, however was to prove successful in the context of financial restraint on the one hand, and the state of the external labour market on the other.

The first nationwide demonstration of industrial militancy in the NHS arose in 1956, originating in a claim submitted by COHSE for an additional "psychiatric lead" payment as their solution for tackling the problem of staff shortages. The strike reportedly involved forty institutions and ten thousand workers (*The Times*, 17th February 1956 and 8th March 1956), but the dispute was unsuccessful. This led COHSE to turn its attention to securing an alternative objective, the payment of overtime rates. A claim for this was eventually submitted to the Industrial Court, but was also rejected. This was followed by a period of unofficial industrial action including sit-down strikes (quoted by Webster, 1988, from Cabinet and Ministry papers of the period).

Despite this "willingness to act", the under-funding of mental hospitals presented a major obstacle to COHSE in securing its bargaining objectives. The industrial pressure COHSE was able to apply proved no more successful in altering this state of affairs than had the appeals from Regional Chairmen for more resources for the mental hospitals, described in Chapter Three. With conditions within psychiatric hospitals not yet having caught major public attention, the powers of each within the matrix of social power appeared relatively weak.

Somewhat more success initially seemed to have been gained by COHSE in its opposition to the Government's own response to nurse shortages, the recruit-

ment of Enrolled Nurses. Although this solution received support from the Nursing Advisory Committee, it had been rejected from within the mental hospitals themselves. Opponents included both COHSE and the psychiatrists body, the RMPA (Webster, 1988). This alliance of opposition must be judged to have been significant in making it successful, illustrating the extent to which local health systems were able to operate with some autonomy, particularly where there was a congruence of interests within the locally negotiated order. Yet, without further funding, the opposition to Enrolled Nurse recruitment had the unintended consequence of increasing the recruitment of unqualified nursing staff.

COHSE's failure to achieve its pay objectives, and ultimately exert control over job entry, provided an early portent of the difficulties facing "industrial militancy" within the NHS when confronted with an unresponsive Government. However, little more in the way of success could be claimed for the response adopted by the RCN to the problems of staff shortages. If COHSE's response indicated the dominance of wage bargaining objectives and "industrial militancy", the RCN continued to show a desire to 'professionalise' nursing with a greater focus upon forms of work organisation.

Urging the recruitment of more domestic orderlies and clerical staff to release nurses, particularly night staff, "for their real nursing duties", (RCN, 1958, p8), the RCN sought a strengthening of the position of Registered Nurses through improvements in nurse training and education. By the end of the period, the RCN was proposing that trainee nurses should have full student status, nursing schools should become more independent from hospitals and provide a more academic education. This echoed several points which had been made in the 1947 Wood Report on nurse training, but with an equal lack of success.

The one element in the RCN policy which was of course adopted was the increased recruitment of less qualified staff. As the proportion of Registered Nurses

within the workforce declined, so too did the organisational base of the RCN. In contrast, despite its initial objection to Enrolled Nurses, COHSE proved better able to recruit them, together with other staff entering the service at the time. COHSE voiced a strong objections to a later RCN 1964 report which recommended that the place of learner nurses on the wards should be taken by Enrolled Nurses and a new "ward assistant" grade (RCN, 1964). The RCN was now accused by COHSE of elitism in reinforcing divisions between Registered and Enrolled Nurses. This was despite the fact that, not many years earlier, the recruitment of Enrolled Nurses had been described as a policy of dilution by COHSE.

While neither of the strategies adopted by the RCN and COHSE achieved its original intended purpose of maintaining the position of Registered General Nurses and Registered Mental Nurses respectively, COHSE went on to demonstrated an ability to respond to the changing composition of the workforce. This laid the basis for future recruitment opportunities. In championing the interests of the newer recruits into nursing against the alleged elitism of the RCN, COHSE also came to argue the case for the practical nature of nursing. On one occasion, its General Secretary objected to the influence of American nursing and particularly the model of "nurse consultant", arguing that, "nursing education must be related to what happens in the wards". (quoted in Carpenter, 1988, p322).

The traditionally more industrial character of COHSE was better suited to the changing workforce than was the professionalising strategy of the RCN. Their relative success in this sense can be judged, not in terms of their impact on events, but the extent to which they each proved capable of accommodating to them.

Meanwhile, early managerial changes were beginning to further alter the social relations within which health unions operated. At first these coexisted with earlier forms, as illustrated in the example provided by Carpenter of a strike in the early 1960's by a group of hospital domestics protesting at the lack of consultation

over the implementation of a productivity scheme. The strike was brought to a speedy end by the matron persuading them to return to work (Carpenter, 1988, p325). The demise of the matron was formalised in the restructuring of organisational control proposed by the Salmon Report, into whose recommendations the RCN appeared to have some influence but was virtually ignored by COHSE.

In one sense the Salmon Report appeared to respond to some of the RCN's concerns, in particular in noting, "a seeming inability on the part of nurses to assert the rights of their emergent profession" (Salmon, 1966). In recommending new management structures as the solution, it created new nursing hierarchies which further bureaucratised workplace relations without, however, achieving the organisational influence its proponents had desired.

It was in this context that concerns over pay began to assume increasing importance. Pay restraint had exacerbated problems of staff shortages and the level of staff grievances: in 1962 a proposed pay offer of 2.5% led to a series of public protests and the organisation of a ballot on industrial action by COHSE, with the RCN also playing a prominent role in separate activities (Carpenter, 1988, p310-315). Despite the willingness of the RCN to take a higher profile on pay-related matters, COHSE became more visible outside of its traditional heartlands, with much of its activity now being centred around general nurses. Membership rose and its composition changed as the recruitment of more general nurses also raised the proportion of women members.

If the catalyst for the introduction into general nursing of more traditional forms of trade union organisation was Government incomes policy, this operated upon a nursing workforce which was changing in social composition and witnessing the decline of traditional forms of authority epitomised in the role of the matron. The restructuring of the workforce within more bureaucratised workplace relations seemed to be favouring organisations having a more unionate character, as the basis for a professionalising ideology was being undermined.

Trade Union Growth (1966-1979)

The dramatic change in union membership figures from the mid-1960's has prompted several explanations, including the impact of Government incomes policy (Bosanquet, 1982), deskilling among nurses (Bellaby and Oribabor, 1977), a more bureaucratised management (eg Carpenter, 1977), and the related aspect of managerial sponsorship. Less attention has been given to the underlying shifts in workforce composition, particularly the recruitment of more less qualified and unqualified staff.

The secondary nature of unions reflected these changes, alongside of which this period saw the character of union behaviour changing in two important ways. The first was in a growing, though highly uneven, willingness to adopt industrial action; and the second was a limited, and again uneven, development of local activity. However qualified, both signified a gradual adoption of a more generalised unionate character. Health services still however provided a contradictory field for recruitment, as was shown in the early 1970's when COHSE chose expulsion from the TUC over registration under the Industrial Relations Act rather than risk being threatened in recruitment by the RCN. Nevertheless, it is important to give some attention to ways in which the character of health service trade unionism was changing in these two areas during this period of membership growth.

Industrial Militancy

An evident change in this period was the increased manifestation of industrial conflict. In 1966 there were just two industrial stoppages recorded in the NHS, causing an average of 0.69 lost days per 1,000 staff; in 1973 eighteen recorded stoppages caused an average loss of 117.8 days per 1,000 staff (Klein, 1983). Of

course the level remained considerably less than in the economy as a whole, and concealed considerable local diversity, but nevertheless signified a growing willingness among broader groups of NHS staff to take industrial action.

In some respects, 1973 can be taken as a watershed (eg Bosanquet, 1982; Dimmock, 1977). It represented, in Bosanquet's words, the breakdown of the "old colonial system" of NHS industrial relations. The ancillary workers strike of that year provided a symbolic break with previous character and practice, even though the ancillary workers themselves gained less than had been hoped from the wage dispute.

During the following twelve months, many groups of NHS staff were to embark on industrial action, including nurses in COHSE and NUPE in the period before and during the Halsbury review. The RCN, while still rejecting industrial action as such, threatened to operate as an agency to supply its nurse members who would resign from the NHS.

The organisational culture was changing. In contrast to Carpenter's earlier description of the role of a hospital matron defusing a stoppage, one hospital administrator, writing in 1974, described local attempts to get porters to accept a "small routine job", previously performed, which had inadvertently been omitted from the bonus scheme specifications:

> the workers' representatives refused to agree and countered veiled threats with rather less veiled threats of industrial action. (Gorham, 1974).

When threats of industrial action spread to the medical profession during the junior doctor's dispute in 1976, a former editor of *The Lancet* complained about the, "conversion of junior hospital doctors to the methods of militant trade unionism." (Fox, 1976). "Militant trade unionism" appeared in many ways to be delivering the goods, although as it was noted in Chapter Three, the impact of

rising wages was to an extent contained as less qualified staff were recruited into the workforce. The apparent success of the "industrial militancy" model must be largely attributed to its ability to impose political pressure on the Government as distinct from its economic consequences. An important illustration of this emerged in the occasional use of industrial action for non-pay and conditions objectives. A notable example of this occurred in 1976 when workers at Charing Cross Hospital in London took the illegal action of withdrawing services from thirty one private patients, setting in train a significant crisis for the Labour Government (Klein, 1983). According to one contemporary newspaper account, Labour Ministers had not until then believed that the Government had any hope of phasing out pay beds in the face of medical opposition (*The Observer*, 7th July 1974). This episode served to emphasise both the highly political context in which health service unions operate and ways in which this could be deployed for non-bargaining, as well as bargaining, objectives.

However, the potential impact of industrial action in imposing political rather than economic pressure had yet to be fully tested. Meanwhile, there appeared to be other immediate benefits for those organisations involved. As one writer observed:

> There is clear evidence of a correlation between COHSE militancy and improved recruitment into the union during the early 1970's. (Taylor, 1980).

By 1979 a different picture was emerging. Pay restraint, together with some improvements in earnings for lowest paid workers, gave rise to several anomalies as differentials were squeezed and the pressure for larger pay increases become unstoppable. The so-called "winter of discontent", although subsequently entering the mythology of the right, presented starkly the potential consequences of industrial action in areas such as health services. Carpenter (1982) suggests that the dramatic growth in membership experienced by the RCN from the late 1970's may

largely be a product of the rejection by many nurses of the method of industrial action. In demonstrating a "willingness to act" through industrial action, health workers found themselves in danger of withholding, not surplus value from the capitalist, but the use value they produced.

Local Union Activity

Rising membership created new pressures for the existing organisational structures of trade unions. The membership of COHSE had increased from just 54,000 in 1960 to 68,000 in 1965, then soared to 167,000 in 1975 and 216,000 by 1980 (Winchester, 1983). Alongside this, moves towards more local activity emerged as unions gained a more formal role through the introduction of procedural agreements for grievances and disciplinary matters. Although their adoption was slow it contrasted with the very limited impact of Joint Consultative Committees in the 1950's.

Within a still highly centralised Whitley Council system, it created the basis for a predominantly representational, rather than bargaining, role for local stewards. As Winchester (1983) notes, the first significant focus for workplace bargaining came with the introduction of ancillary bonus schemes, designed to link pay and productivity. The still relatively slow pace at which change occurred is illustrated in the fact that the first national agreement providing for recognition of stewards and provision of facilities for union representatives was not reached until 1971 by the Ancillary Staffs Council. Not until 1976 was agreement on these reached through the General Whitley Council.

The gradual shift towards more localised bargaining encouraged moves towards a more decentralised structure within the unions. This suggests some support for Clegg's model of the influence collective bargaining structures have upon union behaviour, although the purpose stated by COHSE for introducing a steward

system in 1972 included not only negotiations for incentive bonus schemes but also the need to communicate with members:

> Deductions of contributions at source (DOCAS) meant that branches were in danger of losing contact with their members, while PBR meant that there was a pressing need for workplace union representatives to determine the implications of these schemes and control their introduction to ensure the maximum benefit to members.
> There were additional factors which lay behind the decision to provide a highly localised, effective, and flexible services for members of the Confederation . . . the Donovan Commission, reported in 1968 on the importance of the 'informal' structure in industrial relations, as well as the 'formal' structure provided, in the case of the NHS, by the Whitley Councils. At that time there was no 'informal' structure in the NHS. (COHSE, 1976).

The organisation which went furthest in seeking to adapt organisationally to the new situation was NUPE. Data from the survey of NUPE in 1973/74, although drawn not just from its NHS membership, provides some indication of the changing local organisation in the early 1970's. In 1970, 39% of branches had no stewards and a further 26% had three or less: by 1974, only 11% of branches had no stewards and 56% had four or more. This development of steward organisation was not necessarily accompanied by greater branch involvement in wider union affairs: in 1973 51% of branches sent no delegate to the National Conference for example. But the most significant result for the present discussion is that over one-third of branches stated that neither the Branch Secretary or stewards met management on a day to day basis to discuss members' grievances or problems (Fryer *et al*, 1974).

Many stewards seemed to be purely a means of communication between members and the Full Time Officer. This in fact was virtually the defined role for a steward within the COHSE Rule Book:

> (to) make representation to the immediate departmental head and report to the branch secretary. Further representation must only be taken through the normal branch procedures. (COHSE, 1976).

While union organisation was nevertheless decentralising, it faced a situation in which decisions within the NHS were shifting to the centre. Developments by the late 1970's were to create new demands upon local union organisation as the imposition of cash limits began to have their effect. Initially, the greatest impact was upon capital spending, but those areas which were "losers" under the RAWP formula found themselves with additional difficulties. This gave rise to a series of locally based campaigns to defend services particularly in London; the Elizabeth Garrett Anderson Hospital, Plaistow Maternity Hospital and Bethnal Green Hospital, among others. In all these cases there were attempts to join with users of the services in the local community.

Workers elsewhere were at this time experiencing the problem that industrial action could prove to be a less effective weapon against closure and redundancies. While in all cases convincing arguments could be mounted on the social and economic impact of job losses upon local communities, health service workers were able to draw on community defence for the services themselves. The campaigns nevertheless had mixed outcomes, a notable success being the EGA, buts its particular circumstances were unique. While these experiences did suggest that health workers might have alternative forms of action available to them, their success was not guaranteed.

By the end of the 1970's, health service trade unionism had gained a very high level of membership density, a degree of local organisation, and experience in industrial militancy and campaigning. The unevenness within this needs to be stressed, but despite this a more generalised unionate character had developed than had hitherto been the case. The character had emerged as a product of the experiences of the previous fifteen years, and some early indications of its limitations were to be subjected to many new challenges in the 1980's.

New Challenges in the 1980's

The 1980's has witnessed a dramatic shrinkage in much of the post-war "heartlands" of trade union organisation within the NHS as elsewhere. As the last chapter showed, the large mental hospitals of the 1950's and 1960's have all but disappeared with moves to "care in the community", and the growth in the ancillary workforce of the 1970's has been more than reversed under the impact of competitive tendering and efficiency savings. In contrast, and unlike earlier periods, the proportion of Registered Nurses in the NHS workforce has grown.

Significantly, overall levels of union membership and density have not been altered by these changes. Its character, however, has changed considerably. The organisation which has succeeded in making by far the greatest membership gains has been the RCN. COHSE's membership has remained relatively static, while that of NUPE has declined, although much of this may have occurred in local authorities.

Health unions faced a particular dilemma in the 1980's. Power within the NHS was being shifted towards the centre, but this was as a means of putting pressure on local managers to obtain savings and operate more commercially. This section briefly describes ways in which unions sought to respond to this new situation. The first part considers changing experiences of national pay campaigns during the decade, followed by a short account of one union's review of its own organisational structure. Some final comments are made on prospects for health service trade unionism in the 1990's.

The Changing Character of National Activity

If the ancillary workers strike of 1973 had been a watershed in the breakdown of the "old colonial system", the national pay campaign of 1982 created a hiatus in

the hitherto ongoing development of 'unionateness'. The campaign had united almost all groups of staff around a common claim and was coordinated at national level through the TUC and its Health Service Committee. Lessons had been learned from 1979, with the 'TUC Code of Conduct' guaranteeing emergency cover, and successful efforts were made to maintain public support. Tensions emerged as some local areas were accused by management of failing to meet this Code, and, under the influence of an earlier Government circular, 'If Industrial Relations Break Down', some managers were showing a willingness to adopt a tougher line by sending workers home when not working normally.

The dispute was long running, and brought to a head the problem of mounting industrial action designed to put political pressure on the Government when the Government was prepared to see it through. Calls for escalation were resisted by the TUC, and eventually the Government succeeded in achieving separate settlements for different groups, promising pay review mechanisms for nurses and some others. The 1982 campaign was to be the first, and possibly the last, of its type.

No further national campaign of industrial action was to launched until the ambulance dispute of 1988-89. To a considerable extent this reflected the perceived outcome of the 1982 campaign, in addition to which was the more general demoralising effect of the outcome of the miners' dispute of 1984-85.

The impact of new management systems and policies also had their effect on the focus of union activity, which frequently shifted to a local level. For ancillary workers attention turned to the consequences of competitive tendering, for which negotiations were necessarily local. Some notable examples of industrial action occurred over its introduction although the most prominent, those at Addenbrookes and Barking Hospitals, related to changes in employment conditions with existing contractors. Generally, few NHS ancillary staff seemed prepared to risk strike action on this issue so soon after the 1982 dispute.

Although several writers, as well as unions themselves, pointed to a need for involvement in the specification process in order to gain some influence over the level of service, most evidence suggests little success in this was achieved. Instead, unions were more likely to find themselves able to engage in a degree of bargaining over the conditions of employment for in-house tenders designed to compete with outside contractors (Sheaff, 1988). This suggested that, for ancillary workers at least, the distinctiveness of health care from the private sector was diminishing.

Nurses came to the fore in 1988, in several areas of the country being involved in disputes arising from the application of clinical grading. With the taking of limited action being designed primarily to secure public support, considerable attention was drawn to the issue. The award led to thousands of local appeals, and a corresponding increase in COHSE's membership has been attributed by its General Secretary to this dissatisfaction (*Labour Research*, 1989).

The national ambulance dispute in 1989 broke this more localised trend. Union leaderships sought to run it very differently from earlier campaigns, with greater emphasis upon media coverage and parliamentary lobbying, although at times this generated friction with some local representatives.

One other group of NHS staff began to take a new interest in industrial relations during the 1980's. The introduction of stewards in the British Medical Association, albeit under the title of Place of Work Accredited Representatives, and the appointment of regional industrial relations officers, may imply a perceived waning of traditional sources of influence as a consequence of changes in management organisation.

Much of this suggests not the demise of bargaining over pay and conditions so much as a change in its form, from industrial militancy principally designed to impose political pressure on the Government, to a combination of more localised bargaining and public campaigning. With managerial changes tending to diminish

much of the organisational distinctiveness of the NHS, and with issues and disputes increasingly emerging at a local level, new pressures were being placed upon existing union organisation. Despite tentative moves towards forms of local organisation in the 1970's, the presence of continuing deficiencies was evident in an organisational review conducted by COHSE.

Reviewing Union Organisation: the case of COHSE

Several pieces of evidence suggest that workplace union organisation remained relatively weak in many parts of the health service (Watson, 1988; Cohen and Fosh, 1988). There continued to be a dominance of representational over bargaining activities, extending to the role of Full Time Officers, as one NUPE FTO described:

> The greatest proportion of my time is spent on individual grievances and disciplinary matters. In areas where organisation is weak we are really acting as shop stewards . . . The job is more case-work than organisation. It shouldn't be but it is. (Watson, 1988).

The following considers a report produced by COHSE in 1988, *COHSE: Building For The Future* (COHSE, 1988), intended to address perceived weaknesses in organisation. This describes how the diversification of health care has widened the range of problems with which the union structure must cope in a form which does, "not provide a favourable base for strong trade union organisation." The report notes that apart from the introduction of the steward system, COHSE's structure remained largely unchanged during its period of membership growth and a continuing theme is that the nature of current changes in health care require stronger local union organisation and greater membership participation.

A branch survey conducted for the report indicated that 37% of branches had no functioning Executive or stewards committee, and of those that had, 32% did

not use agendas or keep minutes. Encouragement is given to the holding of work-place meetings for specific issues or work-groups, and the use of branch newsletters designed to improve communication with members. The possibility that the union may lose contact with its members and their needs emerges as a significant source of concern in the report. This is attributed to the pressures arising from the rapid membership growth of the 1970's upon the existing organisational structure.

In commenting on the union's high turnover rate, the report notes that, "A frequent complaint from members who have left COHSE was that contact with the branch was very limited." The report recommends an increased role for stewards, although the branch survey also found that over 40% of stewards and 23% of Branch Secretaries had attended no stewards course.

Two essential requirements are identified by the report: effective local organisation capable of responding to increasingly diverse bargaining needs, and increased member loyalty. In the long term, the former is seen as the route for achieving the latter, but in the short term the mechanism for this is absent. To cope with immediate pressures several short term aims are suggested. These included the establishment of an accurate membership system to improve communication with the members and ascertain their needs, the direct mailing of a relaunched journal to members, and encouragement to members to pay their subscriptions by direct debit. The report adds, "These aims are fully consistent with our long term objectives of decentralisation and devolution".

Nevertheless, they represent centralised solutions to a problem which is identified as being essentially one of insufficient local involvement. This highlights the difficulties facing health service trade union organisation in responding to the new demands created by the changes of the 1980's. The creation of Unison, as with union mergers more generally (Undy *et al*, 1981), similarly represented a predominantly centrally-initiated development. While these were concerned with

organisational adjustment to the changed environment, the character of health service trade unionism might be expected to derive mainly from the more commercial climate operating at a local level.

Prospects for the Future

As with the conclusion on trends in NHS organisation and management in the previous chapter, the possibility of alternative scenarios is apparent. One might be that all work groups become increasingly subject to commercially-derived pressures, encouraging the wider adoption of bargaining methods, with a focus primarily at local level. This is suggested in predictions that groups such as nurses will have a stronger labour market position, enabling them to use local bargaining to their advantage (Fatchett, 1989).

Alternatively, the gulf between staff groups may widen, with some being more subjected to market pressures than others. Managerial challenges to the existing division of labour create threats for some staff but in doing so present opportunities for others. This has had a particular significance for nursing in which the long-standing calls for a more academic basis to its education has seen some realisation in the introduction of Project 2000. Some staff groups may stand to gain from the consequences of managerial attempts to weaken medical dominance.

At the same time, the reform of nurse education has been encouraged by demographic changes, particularly the lower number of future school leavers, and the proposals have been accompanied by others on the introduction of the new grade of Health Care Assistants. In this context, the possibility of Registered Nurses forming a diminishing proportion of the workforce again re-emerges. This time the RCN have appeared to recognise the potential impact this could have upon their own recruitment opportunities, and have debated whether to allow Health

Care Assistants into its membership. Opponents of this policy within the RCN argued that it would undermine the organisation's claim to being the professional organisation for qualified nurses. Whatever the outcome of that debate, it illustrates how benefits arising from restructuring work may be tenuous.

This raises the possibility of a further alternative, that of giving greater priority to issues concerned with services. Possibilities for this are suggested in a report in the *British Medical Journal* which suggested that an outbreak of food poisoning in a London hospital suggested it may have been influenced by staffing cuts brought about as a consequence of competitive tendering. As noted earlier, ancillary unions generally gained little involvement in the specification stage; alliances with other staff groups around issues of service quality might make this more likely.

Allied to this is the issue of public alliances, although difficulties in extending these into permanent coalitions have already been noted. Instead, they have more frequently been of an *ad hoc* type surrounding a particular issue. A challenge this poses for unions is whether an increasingly commercialised environment diminishes rather than extends the opportunities for developing this strategy.

One conclusion which can be drawn from the earlier review is that support is lent to the observation by Bain (1973), that both professional and trade union organisations can be regarded as seeking to regulate jobs in the collective interests of their members. In the changed National Health Service, can this best be achieved through closer association with the employer in the process of achieving efficiency gains, or does the continued distinctiveness of public services call for a qualitatively different approach utilising broader alliances? Is it possible to incorporate elements of both or are they mutually contradictory? The case study material is designed to examine these issues, for which some background material is introduced in the following chapter.

CHAPTER FIVE

PLYMOUTH HEALTH AUTHORITY IN CONTEXT

A single District Health Authority was selected as the location for what are in effect a series of case studies. These provided some diversity to illustrate a variety of processes and influences, while having sufficient homogeneity to make such comparisons meaningful. The inclusion of different occupational groups is intended to allow the relationship between general processes and specific outcomes to be considered. This provides the basis for what Stoecker (1991) refers to as the structural boundaries of the case study, which is further described in terms of the nature of the locality; its economy, employment and trade union movement, as well as the Health Authority itself.

Before this is done a second point made by Stoecker on the case study method is relevant to note. This derives from the distinction drawn by Roy (1987) between functional logic and historical logic. The former is seen as too frequently degenerating into teleology, making it necessary to look at the past if processes of causality are to be identified. From this, Stoecker concludes that the case study must combine its structural boundaries with historical boundaries, again influenced by the theoretical issues underpinning the research. The historical boundaries for this research is the period 1981-1991; a period which encompasses several changes which may illuminate the analytical question concerning the distinctiveness or otherwise of the health service. Although most of the detailed case study material relates to the second half of the period, some earlier background information is included where this is necessary to provide an adequate context.

The purpose of this chapter is to describe the relevant structural and historical boundaries for the case study. It is organised in three sections; the first of which

locates the case study material within its wider local economic and social context. The second looks at aspects of the organisation and management of the Health Authority in terms of what these suggest about the scope and nature of change in the 1980's. Following the theme of the "secondary nature" of trade unions, the character of local health service trade unionism is considered in the final section, together with aspects of the institutional industrial relations context in which they operate. While this distinction is drawn from earlier debates described in Chapter One, the empirical evidence described indicates a close relationship between the two. This provided an important reason for structuring most of the material around specific episodes, and more detailed contextual material for these is reserved for the appropriate chapter.

Economic and Social Characteristics of the Area

Changes within the local economy have been reflected in the changing composition of the workforce, in turn altering the character of local trade unionism. In 1966, 33.2% of the workforce within the Plymouth 'travel to work area' were employed in manufacturing; a figure close to the national average. By 1984, the proportion had declined to 28.7% of the 113,000 people employed, and for the first time a bigger proportion worked in 'other services' than in manufacturing. Despite this, the decline in 'manufacturing' employment had been much less than had occurred nationally in this period.

The continuing importance of manufacturing employment reflected the dominance of the naval dockyard in the city. Plymouth has been a major naval base since the sixteenth century, and this has had an impact on many aspects of the local economy and culture. In 1961 the dockyard employed nearly 19,000 workers, providing almost one in five of all local jobs. Over 15,300 of these jobs remained by 1981, although by 1984 this had fallen to 13,000.

From 1984-87 employment in 'shipbuilding/repair' (mainly the dockyard) fell by over 25%; when the current round of redundancies are completed employment will be little more than 5,000. This does not preclude further reductions arising from the Government's defence review. One consequence has been that between 1984-87 Plymouth was the only major town in the South West to experience a net fall in employment.

During the same period, 'producer services', such as banking, insurance, finance and other business services, have not grown as elsewhere: 3% in Plymouth compared to 15% in the UK, and 17% in the South West. In addition, Plymouth has been one of only two major South West towns to experience a fall in employment in 'high technology' industries. These factors have contributed to making public services dominant in employment terms. With nearly 6,500 people working in the NHS, and with the growing private provision of health care, local health services now rank as the biggest source of employment in the area.

The historic dominance of the dockyard can be identified as a factor contributing to a generally low level of wages within the area. Chalkley (1983) suggests that in the immediate post-World War Two period, the Admiralty may have discouraged the development of alternative employment sources. He quotes from the 1943 plan for the city's rebuilding after the wartime destruction:

> In all sea-port and shipbuilding towns a reservoir of labour is always desired and industries likely to compete for this reservoir are not especially encouraged (Plan for Plymouth, 1943, p25).

Local wages have continued to bear a closer relationship with the predominantly rural area of Devon and Cornwall than with those of other cities of comparable size. In 1990 a study by Glasgow University of the thirty eight largest cities in the United Kingdom ranked Plymouth bottom in average earnings; men's

earnings were 10.6% less than the national average and those of women were 8.6% less (Plymouth City Council, 1991).

The character of local trade unionism is also founded upon the historic dominance of the dockyard in the city, as has been much of the nature of local Labour politics (see for example, Beck, 1974). For many years the key economic issue for the city has been levels of Government spending on the navy; other questions of economic and social policy have rarely achieved a comparable significance. Opening his account of the Fine Tubes strike, Tony Beck suggests:

> By 1950 an industrial relations pattern had been fairly well set for the next fifteen years: a quiescent dockyard, grossly conservative leadership, and a generally low level of consciousness and organisation amongst an inexperienced 'green' workforce (Beck, 1974, p13).

By the late 1960's the area experienced, albeit on a smaller scale, the wave of industrial militancy which had developed nationally. Disputes occurred in some of the local factories which had moved to the area in the 1950's. Companies involved included Tecalamit and, mostly famously, Fine Tubes. By the early 1970's limited industrial action was occurring in the dockyard. Undoubtedly, these changes had an impact upon local organisation: for example, the new TGWU District Secretary who came to Plymouth in the year following the end of the Fine Tubes strike was a Communist Party member from the West Midlands.

The dominance of dockyard trade unions continued to be evident, for example in the composition of the local Trades Council. Although this general influence has in latter years been changing with shifts in employments towards public services, these lacked the cohesion and identity that the industrial dockyard trade unionism possessed. Despite their numerical strength, public service unions have not achieved a comparable institutional or cultural influence.

Organisation and Management in Plymouth Health Authority

Plymouth Health Authority (PHA) covers over six hundred square miles, and provides services for a population of over four hundred thousand. It includes the urban area of Plymouth, with a population of over two hundred thousand, as well as towns, villages and rural areas of West Devon and South East Cornwall.

Substantial changes are occurring the pattern of local health service provision, including the closure of several older hospitals and the expansion of the newer District General Hospital, Derriford. Alongside this increasing concentration of acute hospital services, older psychiatric institutions are being replaced by smaller units and non-residential services in the community. In many cases this is also involving a transfer of responsibility away from the Health Authority.

The following provides a selected account of the impact of managerial changes, described in Chapter Three, upon local NHS organisation. Its structure follows that used earlier, considering the "first wave" of managerialism in the 1970's, and the "new managerialism" of the 1980's. This provides some general indications on how far these changes altered the basic character of local NHS organisation.

The First Managerial Challenge

Evidence from Plymouth Health Authority tends to confirm the rather sceptical approach to the impact of early managerialism suggested in Chapter Three. A continuing tradition of "administration" is evident throughout much of this period, with "managerial" decision-taking being limited. This can be illustrated by considering two areas, both of which have relevance for later comparisons: capital development proposals and staffing levels.

Problems associated with the first of these was most clearly evident in plans for a new district general hospital. The very first capital investment for this was made prior to the establishment of the NHS, during the period of municipal control of hospitals. A site for a new hospital, at Derriford on the northern outskirts of the city, was bought by Plymouth City Council as far back as 1946. Greater central control provided through the establishment of the NHS, and particularly the early capital constraints, prevented any early development in the 1950's.

Nor was it only in major development proposals that centrally imposed financial constraint was evident. Examples from two existing hospitals, Greenbank and Devonport, indicate other problems to which this gave rise. In the case of the former, complaints in the late 1950's that operating facilities were inadequate and dangerous mounted, with allegations that these were responsible for the death of a patient. Eventually Government approval was granted for the building of a new operating theatre at Greenbank in the early 1960's. At this same time a Government inquiry was launched into Devonport Hospital, following the deaths of five patients in 1962 due to inadequate sterilisation of operating theatre equipment. The subsequent report placed the blame upon the combined effect of poor equipment maintenance and lack of staff training.

By the mid-1960's, hopes were being raised that the city would soon be getting its new hospital at Derriford. As reported in a local newspaper at the time, "hopes were high despite the Government's economic squeeze", that work on the new hospital would start in 1970 (*Western Morning News*, 20th August 1966). However these hopes were to be proved unfounded, and it was not until 1971, a quarter of a century after the site had been purchased, that Ministerial approval for development was finally secured.

The hospital eventually opened in 1980, initially replacing services provided at Devonport Hospital. Further expansion since then has continued with the transfer

of services from other older hospitals. This process is expected to continue, with the prospect of it eventually providing twelve hundred beds putting it among the half-dozen largest hospitals in the country.

At the same time that progress on Derriford Hospital was beginning to be made issues relating to staffing levels, particularly among nurses, came to the fore. For example, in 1974 against an establishment figure of two thousand nursing staff in the District there were one thousand eight hundred nursing staff actually employed, ten per cent fewer. Shortages were particularly acute at Devonport Hospital where there were fifty one nursing staff compared to an establishment figure of ninety. The response of local administrators to staff shortages was to identify them as evidence of a problem requiring resolution at national level, with the cause being publicly identified by local NHS administrators as the low level of nurse pay. The District Administrator is reported in a contemporary local newspaper report as saying, "We earnestly hope that when Lord Halsbury's report on nurses pay is published soon that recruitment will increase" (*Western Evening Herald*, 7th September 1974).

Not only was the total nursing workforce below that regarded as necessary, its composition reflected national trends described earlier. Particularly this was the case in a declining proportion of Registered Nurses. Against a funded figure of two hundred and sixty five Registered Nurses in the city's general hospitals in 1974, there were two hundred and seventeen employed; over eighteen per cent fewer. In contrast, the number of unqualified nursing staff, at one hundred and thirty two, slightly exceeded the funded figure of one hundred and twenty eight.

While the Halsbury award appears to have provided a short respite, the problem of shortages of qualified nursing staff was soon to return. Against a background of local media reports of planned ward closures as a consequence, one hospital administrator was reported as saying, "(We are) reaping the consequences

of a lack of money limiting training intakes three years ago" (*Western Evening Herald*, 2nd August 1979).

In overall terms, by the close of the 1970's there is relatively little evidence of a sustained managerial challenge at the local level. Areas of change were beginning to become evident, as with ancillary staff bonus schemes, but in Plymouth these were only very slowly being introduced. Many administrators had themselves been appointed "through the ranks", and appeared to show an identity with other staff. Authority had been traditionally vested in medical consultants and hospital matrons, and while the structures had changed much of the ethos surrounding this had survived.

Local administration rather than management was the order of the day. Organisational changes notwithstanding, much of its distinctive culture continued to reflect a broadly common identity with the delivery of health services, mostly in the context of relatively small, older hospitals. More obvious challenges to each of these came in the 1980's. Much of the more detailed case study material is designed to explore how far this altered the nature of work relations and the character of trade unionism, the following provides a briefer contextual background for this.

The New Managerialism

Of the changes occurring in the 1980's, the introduction of general management was highly significant but not all important. Arguably its greatest role was in further strengthening central control over the direction and character of local responses to centrally imposed objectives. Before its introduction, several centrally inspired policy developments were beginning to shape local health services and industrial relations within them. Most notable among these were the effects of

efficiency savings, competitive tendering and community care policies. All of these are described in more detail in later chapters and here it is simply necessary to note two general points.

Firstly, the introduction of all these policies came during the period of "consensus management", and moreover at a time when many individual managers were the same people who had been influential in the 1970's. Foremost in ensuring their implementation was the pressure of financial constraint.

One consequence of this was that community based services for the mentally ill and mentally handicapped were planned on the basis that they would cost no more than existing services. This decision was to have major implications for the development of these services and was the basis for much subsequent conflict between managers and unions described further in Chapter Seven. The significant point here is that financial constraint had an important impact upon local managerial culture preceding the introduction of general management.

Secondly, the early implementation of these policies had greatest impact upon the organisationally weakest groups within the health service. Only later were stronger groups more directly affected and it was in this process that general management played a more important role.

General management was introduced in 1985 in Plymouth based around two units, general hospitals and community services. This distinction was based upon existing divisions although it was to have further implications later, for example, in relation to different bargaining structures. At this point in time the most obvious impact came with substantial changes in senior management personnel. Several new appointments were made from outside the District although all of the new people came from within the NHS. External appointments included a new District General Manager, previously a Treasurer in another Authority, a newly styled Director of Manpower, and both of the two unit general managers. Some more

limited continuity remained, for example, the previous Chief Nursing Officer remained as Chief Nursing Adviser, but these were relatively marginal.

The introduction of general management coincided with an ambitious target for its cost improvement programme. Plymouth Health Authority's 1985/86 Annual Programme identified a target for the subsequent two years which equated to about two per cent of its cash limit of £58 million *in each year*. No longer was it simply the case of adopting centrally set targets; these were now being raised further. Moreover, the 1987/88 Annual Programme reported that the target for 1985/86 had actually been exceeded by a further one per cent of the cash limit. This was attributable to greater efficiency savings and throughput than anticipated. The latter reduced average costs and subsequently counted as a cost improvement. The main changes contributing to the large efficiency savings were two developments, the introduction of a "cook chill" catering system and a reorganisation of nurse rotas. Because of their significance these changes are examined in more detail in Chapter Six.

By the later 1980's, general managers appeared willing to explicitly embrace some of the more radical proposals being put forward for the National Health Service. The Authority's District General Manager was reported as saying in respect of utilising private provision of health services:

> If the private sector can do it better and more cost-effectively, then I don't see that we should have any political dogma that says it is not an appropriate thing to look at and do (*The Guardian*, 12th November 1988).

Local managers showed themselves increasingly willing to operate alongside commercial operations. The Authority's computer services were put out to a private company, as was the organisation of the "nurse bank", responsible for organising temporary relief cover. A private company, ABC Ltd, was even established by the managers themselves to be involved in income generation schemes. The most

locally controversial decision was to replace an elderly care hospital with beds leased from a private company, and again because of the significance of this it is considered in more detail later.

Such evidence of a willingness, indeed enthusiasm, to embrace the private sector undoubtedly marked a substantial change. However, while in this sense it might be taken as evidence of public service managers increasingly acting "as if" they were capitalists, important elements of the distinctiveness of health services remained. Ways in which these influenced the outcomes of particular processes are looked at later, more generally it is worth noting that by the late 1980's managers and the Health Authority were prepared to express increasing disquiet to the Government about spending levels. In a *confidential* response to the 1989 White Paper the Authority stated:

> The Government has given no commitment in the White Paper to increase the level of resources invested in health. This is despite overwhelming evidence that we as a nation spend relatively less of the national wealth on health services. This raises doubts as to the Government's commitment to the National Health Service. . . . the present level of unmet demand is too high for the public to tolerate. (PHA, confidential response to Dept of Health, 1989).

By this time the Authority's managers were claiming increasing difficulty in identifying further sources of efficiency savings or cost improvements. In fact, early management justifications for seeking hospital self-government gave considerable emphasis to the alleged advantages for obtaining additional resources. In this, the new era of management echoed earlier complaints about the difficulties of obtaining capital within the NHS. It was claimed by local managers that self-governing hospitals would be able to have greater access to capital and on more favourable terms. In addition, considerable emphasis was placed by the managers on the greater flexibility such a move would have upon employment and staffing issues. Again, this had been an area under strict central control since 1951.

A paper summarising a private discussion of Health Authority members and managers on the Government's 1989 White Paper stated:

> The emphasis given to the principle of competition is, however, overstated. . . . The advantages of self-government lie in increased independence and flexibility rather than in competition. (PHA, internal document, 1989).

This highlighted the way in which general management, encouraged to behave more commercially, was operating still in a highly centralised structure. This confirms the continuation of the NHS as a highly political system in which control by the Treasury has mostly been paramount. It also illustrates the considerable change occurring in managerial attitudes over the course of a decade or so. In the late 1970's issues concerning capital developments and staffing shortages had not been seen as amenable to local resolution: by the late 1980's managers were seeking greater autonomy in order to tackle them. This, however, is not the same as a wholesale commodification of health care services.

Before returning to this point in considering individual episodes, the following reviews aspects of the organisation of local health service trade union organisation and industrial relations. Whereas in earlier chapters an attempt was made to consider institutional and wider social influences separately, these are brought together in this account as a means of illustrating aspects of inter-relationship.

The Character of Local Trade Union Organisation

Much of the character of local union organisation reflected its secondary nature, derivative of the social relations of which it is a part. These are not, at least directly, organised by capital so much as the occupational division of labour within health care. The distribution of staff across occupational groups in the mid-1980's is shown in Table 5.1.

Table 5.1: The composition of the workforce in Plymouth Health Authority in 1984 (in Whole Time Equivalents)

Medical & dental	175
Nursing & midwifery	2846
Prof supp to medicine	219
Pharmacists	14
Technicians	211
Opthalmology	4
Scientific staff	22
Admin & clerical	642
Works craftsmen	98
Works officers	21
Ancillary	971
TOTAL	5223

In many ways the distribution of membership between organisations reflects occupational boundaries. For example, NALGO is the predominant organisation among administrative and clerical staff, as is MSF (from ASTMS membership) among professional and technical staff. Some other staff tend by and large to be in the particular organisation representing that group, such as health visitors, occupational therapists and midwives. Works department staff remain largely with the union representing their own trade. These groups however do not form a major focus for the current study.

But descriptions of patterns of membership say little about the form which it takes. For this to be understood it is necessary to deal briefly with significant traditions upon which these have drawn. The organisation having the longest and most readily identifiable local history is undoubtedly COHSE, based originally within the mental illness services. For example, the Moorhaven branch of COHSE is recorded as affiliating, as the then NAWU, to the Plymouth and District Trades Council in the 1920's soon after the General Strike.

The post war years appear to be characterised by close co-operation between the union and the hospital management. Throughout much of this period, and before, the most notable union representative at the hospital was Claude Bartlett, president of the National Asylum Workers Union and later of COHSE for over one-third of a century. He also became the last ever lay Chairman of the TUC. Although achieving no grade higher than a staff nurse at Moorhaven Hospital, Claude Bartlett was to sit on the Royal Commission which led to the 1959 Mental Health Act. He in many respects reflects a combined identity of trade union bargaining and wider job-related concerns. This involved a close incorporation into the locally negotiated hospital order, an indication of which appears in comments made by Moorhaven's Physician Superintendent in 1959:

> The hospital is proud of the honour of having the Chairman of the General Council of the TUC on its staff. . . on many occasions he has been of great help to the administrative staff of this hospital. The award of CBE to Mr Bartlett in the New Years Honours of 1960 is richly deserved (Moorhaven Hospital Annual Report, 1959).

The success which COHSE achieved at Moorhaven was not matched in the general hospitals. Interviews with a Branch Secretary of Devonport Hospital in the 1940's and 1950's revealed outright opposition, particularly from the hospital matron, to union organisation. This was illustrated in one war time episode when a young nurse, a union member, requested leave to marry her fiance who was briefly

returning from the front. The nurse had her request to the matron refused unless she left the union.

The 1960's appears as a period of transition in two respects. As elsewhere, recruitment began to develop in the general hospitals but at the same time, and certainly by the early 1970's, the degree of organisational incorporation in the mental illness services seems to have waned. In creating the beginnings of a new climate in the general hospitals the early managerialism may also have created new and alternative opportunities for individuals wanting greater responsibility within psychiatric nursing.

Within the general hospitals, managerial sponsorship, though it may not have been the only cause of this change, undoubtedly left its imprint upon union character. Two examples can be used to illustrate this, one drawn from ancillary staff and the other from general nursing. On the first, according to one local manager, the GMWU and COHSE were encouraged by management in the 1970's who saw the growth of ancillary worker trade unionism elsewhere and associated outbreaks of militancy with the presence of NUPE. This encouragement of union growth was associated with the development of a personnel function within the District, and can be seen as reflecting a form of incorporation rather different to that which earlier prevailed within Moorhaven. It was founded upon bargaining relationships with administrators, even if primarily representational in content, rather than being a part of more distinct hospital identity and ideology.

A closer form of this was more evident in the case of the RCN in the 1970's which grew among general nurses. Despite a rising membership, local organisation was weak; its organisational influence derived to a large extent from the support of senior nurse managers. Much of its organisational activity locally had been associated with "professional" concerns, including the arrangement of seminars and the like. By the early 1980's some of the most notable local activists were nurse

managers. For example, in one year the local branch was represented at the annual conference by three male "career" nurses; a director of nursing services, the nurse personnel officer and a young charge nurse who was seen by many to be aspiring to career advancement. In other words, the form of managerial support which encouraged the RCN was substantially different from that which had "sponsored" ancillary worker unionisation.

At the same time, the 1970's had seen a considerable formalisation of joint consultative arrangements involving all staff organisations. This included the establishment of a Joint Consultative Committee, and a parallel Health and Safety Committee, providing important vehicles for formal management-union relations. To a large extent they also encouraged a separation of bargaining activities as a specialism, both for managers and union representatives. These arrangements were largely unhindered by the 1979 industrial action, of which very little occurred in Plymouth health services.

The influence of District level bargaining procedures was evident in the form that subsequent union organisation took. For example, in the late 1970's separate COHSE branch organisation at Moorhaven and in Plymouth general hospitals ended, with the creation of a single "group branch" covering the Plymouth Health District. This merger was actively encouraged by regional COHSE officers on the grounds that it made better sense for union organisation to correspond with NHS organisational structure. Critics within COHSE of this process suggested it had more to do with reducing the number of Branch Secretaries with whom the regional office needed to maintain contact. Whatever the case on this, its effect was to reinforce the focus of much union-management relations at the level of district administration in which a relatively small number of union representatives were involved.

The COHSE branch merger was accompanied by a continuing decline in union activity in its earlier stronghold at Moorhaven. At one point in the 1970's a

dissatisfied COHSE nursing steward left with a group of members to join the GMWU. These in fact appear to have rejoined COHSE, not least because in 1980 the Moorhaven COHSE members reformed a hospital based branch. In any case, the GMWU, which had been effective principally in recruiting ancillary staff throughout the district, had a similar lack of active involvement. Most representative activities fell to a single convenor.

These district-wide arrangements were, however, to come under considerable strain in the early 1980's. Highly significant in this were changes within the unions but which can be seen to have been prompted by influence of external changes. This included new groups of staff joining the workforce and union Full Time Officers seeking involvement in what had predominantly been a lay system of representation.

An important example of the first of these came as a consequence of the economic recession, specifically in the closure of the Plymouth Fisons factory in 1981, a plant having a strong GMWU base. Several of the workers, including stewards, gained employment in Plymouth Health Authority at this time. These brought with them a different experience of trade unionism than that of most other stewards, having greater expectations for the role of workplace bargaining and being unused to the centralism of Whitley.

A second source of change arose within COHSE with the new development of mental handicap services. No traditions of local union organisation existed within mental handicap services given their relative newness. COHSE immediately achieved a dominant position in the new units, partly as a result of new qualified staff coming to the area who were already COHSE members. One consequence of qualified staff having to be recruited from outside the area was that the new mental handicap service gained a higher proportion of younger members than might otherwise have been expected.

The senior nurse for mental handicap was both fairly young and a COHSE member himself. Despite the more fragmented basis of the new units, this sector sustained a far stronger union organisation than was the case at the single site Moorhaven hospital at this time. The degree of concentration of workplace structure is clearly only one factor to take into account in explaining union decline. One consequence was that it brought into the local COHSE branch predominantly younger members, many of whom had experience of union activity.

Together, these two changes brought new activists into two of the largest unions. In voicing criticisms of many elements of the existing consultation and bargaining relations, some support was received from other members who described it as being, "too cosy". This in itself may not have altered the state of affairs for some time, had it not been for Full Time Officers taking a role.

This came about as a result of a dispute over claims that the constitution of the joint consultation machinery prevented attendance by Full-Time Officers. As a consequence of the membership growth in the 1970's, more full-time officers had been appointed by TUC unions and they now began to take a greater interest in the joint consultation forums than appears to have been the case at their inception. In particular, they began to raise concerns about the quality of some of the agreements which had been reached. The issue came to a head at one particular meeting of the Health and Safety Committee in 1981 when three full-time officers from COHSE, NUPE and GMB arrived to present objections to aspects of a newly drafted accident report form.

Several representatives on the staff side from non-TUC affiliated organisations objected to their presence, and the issue of full-time officers right to attend was then put to a vote. In itself this appears to have been an unusual procedure as most issues had been resolved consensually. Because of the larger number of smaller non-TUC affiliates, most of whom did not have full-time officers at local level,

a majority of the staff-side determined that they did not wish full-time officers to be in attendance.

The issue drew a new line between TUC and non-TUC affiliates but also brought to the surface concerns among some sections of union membership that the existing arrangements were unsatisfactory. It is possible that the issue might have been resolved relatively smoothly had it not been for the fact that it coincided with the beginnings of the 1982 health service pay claim. The TUC unions at a national level were seeking to co-ordinate their activities but in Plymouth the JCC reached an informal agreement with management on avoiding any disruption. This created further grounds for opposition from within TUC unions, and extended the issue beyond that of procedural revision to the JCC constitution.

Two developments occurred as a result of this. Firstly, representatives of ASTMS, which had always objected to sitting down with non-TUC affiliates, together with COHSE, GMWU and NUPE, organised an *ad hoc* "Joint Action Committee" to co-ordinate industrial action. Secondly, internal changes occurred within certain unions. Most notably this was the case with the replacement in the GMWU of the existing convenor by the former senior steward from Fisons. Less acrimonious changes occurred in COHSE, with the Chair of the Action Committee being elected Branch Secretary. The former GMWU convenor responded by using the local media to accuse new GMWU and COHSE activists of importing unwanted militancy into local industrial relations.

For much of 1982, attention was focused on the pay campaign. This was the first significant occassion in which Plymouth health workers had taken part in such a campaign, let alone one so prolonged as this was to be. At least in the short term it gave rise to new levels of member activity, particularly among ancillary membership. It was among this group at the new Derriford Hospital that the GMB established a strong basis. The hospital, lacking the localised traditions of older hospitals, provided the site for much of the industrial action during this year.

This process of internal union change was however a very uneven one. Not all TUC affiliates were involved in the Action Committee, and some, notably NALGO, were highly critical of some of its actions. On one occasion a group of cardiac technicians, who were NALGO members, were disassociated by their branch secretary for industrial action they took. The group then left NALGO to join ASTMS.

Despite the unevenness of its impact, the 1982 dispute brought the "old order" to an end. It had brought to the surface a number of underlying changes which were taking root. However, the dispute ended with an outcome which delivered least for the ancillary workers who, in Plymouth, had been the most active participants. Moreover, by 1983 many of them faced the imminent implementation of competitive tendering. In this situation some form of negotiating machinery had to be re-established.

Despite the frictions between TUC affiliates themselves during the dispute, some of which had maintained an involvement in the JCC, support was won from a majority to establish a Joint Trade Union Negotiating Committee (JTUNC) representing TUC affiliates only. An approach was made to management for recognition which was refused on the grounds that the Authority wanted to meet staff representatives within a single body. The response of the TUC affiliates was to refuse to participate in what by now had become a virtually irrelevant committee, and instead proposed to take every matter to management through individual organisations.

This non-participation in the Joint Consultative Committee placed increasing burdens upon district personnel staff. As a result of this it seemed at one point that an agreement to give *de facto* recognition to the JTUNC had been reached with the District Personnel Officer. This was however over-ruled by the District Management Team. Eventually a compromise was reached that established a Joint Con-

sultative Committee (JCC) to include all staff organisations, providing within its constitution for sub-committees: in practice the only sub-committee to operate was the JTUNC. The latter met management on a monthly basis, with bi-monthly meetings of the JCC. TUC affiliates saw it as an opportunity to reach agreements through the JTUNC which would then require only formal ratification at the JCC. By now, objections to attendance by Full Time Officers had faded away.

Problems were nevertheless experienced with the new arrangements. The first arose as a consequence of senior district managers and two Health Authority members attending the JCC, whereas the management side meeting the JTUNC was composed of the District Personnel Officer together with middle-ranking managers. This frequently led to an inability of the management side to reach agreement. An additional difficulty experienced by the JTUNC arose as a consequence of its Secretary having considerable difficulties obtaining time-off to carry out the duties required. This was compounded by the fact that in 1983 he was elected as an SDP County Councillor for which he required further time off.

In this case the difficulties were not created by senior district management but his own manager who was a medical consultant. The problem led to the registering of a dispute by the JTUNC unions, eventually heard at regional level. While an apparently satisfactory compromise was reached, in practice the difficulties continued. The impression was created that the consultant who was head of the department concerned was unwilling to be instructed on the matter, particularly from personnel managers. It indicated again the tendency towards seeking managerial support for sustaining union organisation in the context of more hostile internal sources of authority.

However, the basis of this support had primarily been from personnel officers. The situation was to change again with the arrival of the new general management structure. It was made clear that the management side intended to

have one forum for consultation and negotiation, and within a year agreement had been reached to disband the JTUNC and a single Joint Committee for Consultation and Negotiation (JCCN) was established. This time there was little resistance from the TUC affiliates.

An underlying reason for this was that institutional mechanisms were reflecting changed relationships between unions and different groups of managers. An illustration of this is provided by the GMB, which unlike many other of the staff organisations defined itself almost exclusively in a bargaining role. The GMB had by now firmly established itself at Derriford Hospital, and was benefiting as services transferred there. GMB health service members, who had been part of the union's general branch were now transferred into a new health service branch. This was used to try and overcome what it had perceived as a reluctance by some health staff to join what they saw as an "outside" union. In this it appears to have enjoyed some success, for in addition to recruiting the majority of ancillary staff at Derriford the union began to attract many nursing assistants as well as some qualified staff.

The GMB however did not make bargaining its sole concern. It, more than any other organisation, sought to gain members interest in other ways; family fun days, social evenings, raffles and suchlike. Yet, its focus within the workplace upon bargaining activities meant that it developed relationships principally with the new general managers.

In contrast, organisations which had relied upon support from other sectors of management found themselves increasingly vulnerable. This was particularly the case for the RCN and COHSE. The extent of nurse manager involvement within the local RCN created tensions which in some cases proved irreconcilable. Most notable was that of the Director of Nursing Services referred to earlier, who eventually resigned over a refusal to implement what he saw as unacceptable cuts in the nursing budget. He later became a full time officer with the RCN.

The continuing impact of this pressure upon the RCN remained evident, as in 1990 when a Trust application was being made by management, an RCN poster appeared in local hospitals stating: "Do not wear the opting out badges. You could be disciplined by management". At the same time several individual RCN representatives have been willing to speak out publicly on their concerns over funding, staffing levels and other issues. It was however apparent that support from nurse managers no longer meant as much as it had previously.

The changing relationships between unions and general management were consequently reflected in the new consultative and negotiating systems. What was new was not the presence of accommodation but rather the form that it took. The only staff organisation which did not take up their seat on the newly established JCCN was the BMA, representing the hospital doctors. This reflects the distance which the BMA has traditionally kept from other staff organisations. In August 1989 however the medical staff indicated that they would take up their seat, largely as a consequence of the local proposals arising from the Government's White Paper, but in practice this did not happen.

Before leaving the issue of the relationship between bargaining structures and the character of union organisation one further example illustrates its sometimes complex nature. This case concerns St Mary's Hospital, Launceston, referred to in more detail in Chapter Eight. Most of the staff in the hospital are COHSE members, the majority having had long periods of employment in the hospital. Although employed by Plymouth Health Authority, because of the structure of COHSE branch organisation they are members of its Cornwall Branch. That branch covers a very large geographical area in which transport facilities are not good. Union activity in the Cornwall COHSE Branch appears to be mainly within the larger hospitals in the county, at least so far as the presence of branch officers and stewards is concerned.

Membership of the Cornwall branch reflects an identity with the county even though the employer since 1974 has been Plymouth Health Authority. A further factor may be the reluctance of branch organisations to encourage a transfer of members elsewhere when this will have an impact on levels of branch funding. The consequence was that the branch of which the St Mary's staff were members was not formally represented on their own employer's bargaining structures. One result of this was that the full time officer came to play a particularly important role. It nevertheless illustrates how identities can sometimes be generated from a variety of sources, not always corresponding with bargaining units.

This review has suggested the importance of unions establishing support from sections within management, with the particular group being involved varying at different times and for different organisations. It was also noted how the introduction of general management appeared to cut across existing networks and require the establishment of new ones which recognised and accommodated with its presence. Before leaving this general introduction one other point is worth highlighting, concerning the role of activists within the unions.

GMB organisation at Derriford appeared to suffer when the union appointed its Health Service Branch Secretary as a part-time officer, while retaining part-time employment with the Health Authority. Eventually he left the area to take up a full-time officer post and the branch organisation seemed weaker as a result. Similarly in COHSE, throughout the early 1980's problems were experienced in maintaining the single District branch, with most dissatisfaction being expressed by those outside of the general hospital sector. In 1986 the COHSE branch divided into a community services, comprising mental illness, mental handicap and elderly services, and a general hospital branch. These broadly corresponded with the new general management units. This development appeared, in the case of the community service branch, to stimulate activity but this was not the case for the general hospital

branch. The division of the branch had resulted in most activists being in the community services branch and it was at Derriford that its organisation was weakest. COHSE involvement in the general hospitals therefore placed a heavy reliance upon the full time officer.

To recognise the role of key individuals is not to reduce explanation to that factor alone. Such people seemed most important where they were part of an identity built around a clear definition of purpose. In this they played a vital role in expressing and articulating concerns of members. How such concerns came to be related to objectives, and how these were defined, is an important theme in the individual episodes in the following chapters.

These episodes are used to explore themes identified earlier. In approaching the question as to whether or not health services are becoming less distinctive, attention is given to the NHS as a political system, the nature of negotiated order within it and the scope for conflict and accommodation. This is used to consider examples of union behaviour which relate to the alternative strategies described in Chapter Two. An important question is whether these represent complementary or alternative strategies, and for this reason the chapters are structured around the dominance of bargaining (Chapter Six), the relationship between bargaining and professional issues (Chapter Seven), and the relationship between bargaining and campaigning (Chapter Eight). The representational strategy is not discussed separately for the reason given earlier, that its full expression requires additional legislative support. Nevertheless, within many of the issues considered the role of individual representation arose as an important factor. The main focus, however, is not upon this but the extent to which bargaining, professional and campaigning strategies can be judged as mutually supportive or exclusive.

CHAPTER SIX

THE POSSIBILITIES AND LIMITS OF PAY BARGAINING

The historic dominance of collective bargaining within British trade unionism has already been noted, together with its emergence as an influential feature of health service trade unionism. Although here it was of a form highly constrained by the centralised Whitley Council system, efficiency drives linked with incentive bonus schemes, as encouraged by the National Board for Prices and Incomes in the 1960's, provided an early stimulus for more localised negotiations. The main direct impact of this was nevertheless restricted to ancillary staff.

Developments occurring within the NHS described in Chapter Three have substantially increased the pressure for efficiency and labour productivity improvements. As was also noted, the major consequences have been felt by ancillary staff although other indications suggest a widening impact. These developments give rise to two principal questions. Firstly, it is important to test the proposition that these changes are constraining local managers to act "as if" they were capitalists in their control over labour. Secondly, if this is the case, is it reducing the distinctiveness of the labour process within health care in ways which make the adoption of a more bargaining-based model more relevant for wider groups of staff?

These general questions provide a guiding theme to much of the case study material in this and the following two chapters; here the focus is principally upon ways in which managerially inspired changes designed to improve efficiency were responded to by unions. Given the general impact of policies such as these upon ancillary staff this group provides the main focus. A specific example of change is selected, that which produced the highest level of efficiency savings, the introduction of technical change in the catering service. To enable wider comparisons to be

drawn some attention is also given to an attempt to raise efficiency in the organisation of nurse work rotas. For comparative purposes they have the advantage of each being hospital, rather than community, based.

The two examples provide an opportunity to compare the relationship between the character of trade unionism in the two groups on the one hand, and the forms of institutional support provided by management on the other. In this, the focus seeks to move beyond a dichotomy between industrial relations bargaining systems and sociological aspects of union character to identify the importance of each and their inter-connections.

The discussion focuses upon both processes and outcomes. The particular processes being examined in the two cases are slightly different but have in common the relationship between formal institutionalised bargaining and other ways in which order comes to be negotiated within the social relations of the hospital. This issue is approached by looking at how the policies originated, the initial response of unions and how this came to change in each case. Outcomes are considered in terms of what was achieved, but also in what the forms of accommodation which were reached suggest about the nature of workplace bargaining in the health service today. In particular, has an increased role for commercial factors weakened the unions or have they been strengthened by the opportunity for a more genuine bargaining rather than predominantly representational role?

Efficiency, markets and technology: the case of ancillary staff

Technological change in the delivery of catering services occurred under the twin pressures of financial restraint and competitive tendering. In place of the traditional system of catering, which had been dispersed throughout the District with all hospitals having their own kitchen facilities, the new system involved food being prepared in a Central Production Unit (CPU), chilled and subsequently delivered to outlying hospitals by refrigerated lorries. Much of the initial stimulus for management interest in the system came from the threat of competitive tendering. Indeed the senior manager most closely involved in its implementation later claimed that, "Plymouth decided upon a delivered meals service in response to the challenge of HC(83)18" (*Health and Social Services Journal*, 24th January 1985).

"HC(83)18" was the Government circular which required of health authorities that they "market-tested" catering, domestic and laundry services via the mechanism of competitive tendering. Given its role in influencing management's plans, it is useful to briefly identify some aspects of the local Health Authorities response to the policy. The reply of Plymouth Health Authority to the Government's original consultative circular, DA(83)14, had included the comment that, "It is in broad agreement with the principal thrust of the circular, ie to ensure that support services are provided in the most effective manner". However, it went on to suggest:

> A straightforward cost comparison is not the only criterion Health Authorities should use. The ability to purchase a substantially improved level of service albeit at a slightly higher cost should also be considered (internal Health Authority paper).

Doubts about the quality of service which might result, particularly from the use of private contractors, is very evident in this response. So too, according to one

personnel officer in the Authority, it lay behind the brief which managers had been given: to ensure that services remained in-house. The significance of this is particularly important in the context of the view which seems to have been taken by some senior Health Authority members about wages within the NHS. It may have been the 1982 pay dispute itself which brought this to the fore, as illustrated in the following extract of a letter sent by the Chairman of the Health Authority to the JTUNC soon after the competitive tendering policy had been announced:

> It seems to me that competition is beneficial and in this case has brought to light one or two interesting aspects of our wage structure. During the industrial action some time ago I heard on the radio that it was the view of Trade Unions that the conditions of employment of workers in the Health Service compared ill with the rest of the community. It would now appear that our staff are apprehensive that there are other people outside who are prepared to do the work they do for markedly less.

The significance of this lay in the signal it sent that existing internal wage structures were to be closely examined in the process of competitive tendering. It was in this area that some of the greatest effects of the new cook-chill catering service were eventually to be felt. Before describing how this came about it is important to note some significant features of the existing catering workforce.

Of the total workforce throughout the district of one hundred and eighty nine, the overwhelming majority, seventy nine per cent, were women. In turn, slightly over half of these women worked part-time. Union organisation was patchy. Staff in the larger hospitals had been involved in taking industrial action in 1982, and a legacy of this had been the involvement of several representatives, most of whom were young male cooks. Although union membership tended to be high, throughout the service as a whole levels of involvement were (with this main exception) generally low. Virtually all staff were members of either COHSE or the GMB, the latter being strongest in the main Plymouth hospitals which were most closely involved in the negotiations.

Details of the proposed operation of the new system became available in 1984 in a management consultants report commissioned by the Health Authority. The immediate response from the unions was to find ways of resisting its introduction in the light of the substantial threat to jobs which it represented. Management responded to this fear in two ways. Firstly, it was argued that with competitive tendering now on the horizon it was essential to have "in-house" services operating effectively. A second claim from management was that the new service would provide, "the opportunity for the NHS to increase the skill levels and career prospects of its catering staff" (*Health and Social Services Journal*, 24th January 1985).

The unions nevertheless initially maintained a position of opposition. This period was characterised by joint union involvement in a lobbying exercise designed mainly to persuade Health Authority members rather than senior management. It was accepted that the jobs argument alone was unlikely to be persuasive for this group, and emphasis was instead given to aspects of food hygiene and safety. A report detailing alleged potential microbiological and other hazards was produced and sent to Health Authority members.

It would be wrong to see this as a cynical use of safety issues as a covert attempt to protect jobs as there was a genuine distrust of the new technique. However, the arguments proved unsuccessful. Significant in this was the fact that the Authority's own senior microbiologist argued that, with adequate control methods, the system presented no additional risk of food contamination. This also proved to be an important factor in reducing the ability of the unions to attract the concern of the local media.

With this reassurance the Health Authority was unwilling to forgo the level of savings involved which were substantial. Although the proposed system required a large capital investment, equivalent to one-third of the Health Authority's annual catering budget, it was expected to reduce annual catering costs by eighteen per

cent. In this context the unions found themselves finally unable even to secure the support of the TUC nominee on the Health Authority. The phase of opposition came to an end.

Union attention turned instead to negotiating over the introduction of the new system. The implications of the new service for jobs were profound: an overall reduction in staff numbers by twenty five per cent was to be accompanied by additional reductions in hours of work as well as other changes in grades and earnings. Having failed in their opposition to the system, many union representatives did not feel they were likely to achieve any significant change in the numbers of jobs being lost: this after all provided much of the justification for the system. Instead, most attention turned to pay arrangements within the proposed system.

Having a significant effect upon later developments, early negotiations centred around the staffing arrangements for the CPU. For management this was the fulcrum around which the new system was to be built, while simultaneously being the work-site promising the highest potential earnings for staff. Once union opposition to the plans had been withdrawn management demonstrated a considerable willingness to provide facilities, in the form of time-off and the like, for union representatives to participate in negotiations. The initial focus upon the CPU was further encouraged by the fact that opportunities within the Unit would be largely restricted to qualified cooks, who provided the most prominent catering union representatives during negotiations. During this process the new GMB Secretary was highly involved, drawing upon his experiences of more localised bargaining.

The process of focusing early negotiations upon the CPU influenced the final outcome because of the existing structuring of labour, both by capital and by gender. The former showed its presence in the influence of the external labour market, while the second was evident in the internal composition of the workforce. The two processes operated in mutually supportive ways.

The negotiations concentrated upon what were to become the "elite" jobs: about fifteen cooks who would be responsible for cooking meals for all hospitals throughout the District. An immediate problem confronting both managers and union representatives arose from the intention to operate the CPU during day-time from Monday to Friday only. Given that a major element of earnings for many ancillary staff derives from enhanced rates for evening and weekend working, management recognised potential recruitment difficulties which it was keen to resolve as quickly as possible.

External labour market factors came to be considered because management were aware that the staff who were being sought would have alternative opportunities available to them, particularly employment in local hotels. Much of the very early negotiations had the resolution of this problem as their objective. One other hospital in the country was identified that had already introduced a similar system, the London Hospital at Whitechapel, and management organised a visit with union representatives to jointly investigate how they had dealt with this problem and others.

On return to Plymouth, neither managers or unions were impressed with the solution they had found in London. There the hospital had overcome the recruitment problems of keeping the CPU staff on the low-paid ancillary staff scales by transferring them to grades on the Administrative and Clerical Council grades. This solution was not acceptable to the Plymouth management, who felt it was likely to cause difficulties with the Department of Health, and the unions, particularly those representing ancillary staff, were equally unimpressed.

As it was to be another two years before the Ancillary Staff Whitley Council considered an agreement for cooks working in cook chill systems, the problem remained to be resolved at local level. After considerable negotiations a local agreement was reached. This involved placing CPU staff on a high grade within the

Ancillary Staff scales and in addition to guarantee them a thirty per cent bonus payment. For management this was acceptable as it produced an overall earnings which reflected their readings of the local labour market, a view later confirmed in an interview with the new catering manager appointed from the private sector to introduce the new system. For the unions it was acceptable as it would maintain, and even enhance, existing levels of earnings.

This issue having been resolved a further important question concerning the CPU remained outstanding: the method of selecting the fifteen staff to work within it. It is interesting to note that management were prepared to accept even this, to a limited extent, as a negotiable issue. Throughout, the unions had linked this to their negotiations on earnings, a stance which received considerable support from the fact that the cooks who would be eligible to apply were stating that they would not do so until an acceptable procedure was adopted. This solidaristic stance was at the same time highly sectional in being restricted to a comparatively small section of the catering workforce.

Inevitably, there were many more cooks working throughout the District than the new system would require. Management demonstrated a willingness to adopt a joint approach with the unions to determining a broad set of criteria for selection while maintaining the final right to decide. After considerable negotiations a formula was devised that would give weighting to length of experience, qualifications, and finally an interview on which a union representative was invited to attend as an observer.

The relative weighting to be given to experience and qualifications was to have considerable implications for the outcome. The existing workforce contained many female cooks who had been in the service for long periods of time but held minimal formal catering qualifications. These were more frequently possessed by younger cooks who in the majority of cases were male. Management were insistent

that the new posts demanded skills for which a higher grade of City and Guilds qualification was to be required, and the formula for appointment was weighted accordingly.

Although the initial demand for this came from management it was largely acceded to by the unions without accompanying calls for the release of staff for further training. Although there would have been difficulties in this, created by pressures to get the system operating quickly and smoothly, it also tended to strengthen the chances for the cooks who had been most involved throughout. It has also to be said that many of the longer-serving female cooks had worked for many years in smaller, outlying hospital kitchens, and appeared less interested in the opportunities offered by the CPU in any event. This is difficult however to disentangle from the nature of union organisation which was strongest in the larger hospitals and in which male cooks were prominent.

The negotiating emphasis upon the CPU was however leading to some expressions of dissatisfaction from other staff, notably some of the unqualified catering assistants who were predominantly female. The view was expressed by a group of catering assistants at one hospital that while a lot of time was being spent discussing the cook's posts, very little was being directed to addressing their own future. The reply of the GMB Secretary on one occasion when this was asked, and this seemed generally acceptable to other representatives, was that it was important to get good agreements in place for the cooks in order that others could follow in their wake.

Whatever the intentions in adopting this process, it was not to be reflected in the outcome. Two aspects were important in this. Firstly, despite the claims for the new system that it would improve career opportunities and skill levels it was in fact to create a more segmented workforce than had been the case previously. This can be illustrated by comparing the composition of the workforce by ASC grade before and after the introduction of cook-chill, shown in Table 6.1.

Table 6.1: Composition of catering workforce by ASC Scale before and after the introduction of "cook chill"

ASC pay group	% before	% after
1-4	59.8%	79.0%
5-8	31.2%	4.5%
9-12	6.9%	12.0%
13-16	2.1%	1.5%

The increase in the proportion of staff in the bottom four ancillary grades, from nearly sixty per cent to almost eighty per cent, had particular impact upon women who filled the majority of these grades. Ninety two per cent of posts at these grades had been occupied by women under the previous system. This bifurcation of the workforce reflected the fact that the new technology had been introduced in a way which involved enhanced skills for some and deskilled others. The consequences of this upon earnings was to become even greater when it came to negotiating bonus payments for staff other than the CPU cooks and it became evident that different considerations would apply.

Under the previous catering system, all staff had been covered by a traditional incentive bonus scheme, giving them a bonus payment of either ten or fifteen per cent, varying slightly between hospitals. Management now argued that the imminent threat of competitive tendering precluded the continuation of that level of bonus. This was despite the fact that agreement had already been reached on an automatic thirty per cent bonus payment for CPU cooks.

Negotiations produced an agreement that bonus payments for non-CPU staff would in future depend upon savings achieved within the allocated budget. One GMB Full Time Officer involved in the negotiations described this in terms of it being a form of "profit sharing". While it provided an opportunity for retention of some bonus payment which would otherwise have been difficult to secure, it underlined the different status of the two groups of staff.

A final element of the package arising from this phase of negotiations concerned redundancy terms for staff leaving the service as a result of the change. Within the NHS, redundancy payments are covered by national agreements reached on the General Whitley Council and it was agreed by management to supplement these with additional local payments. While the amounts involved were not substantial it nevertheless represented a further symbolic departure from national agreements. The willingness with which the more localised bargaining was embraced was uneven between unions, with the GMB being generally more enthusiastic than was COHSE. This very much reflected the role of local officials, both lay and full time, and their respective experiences and traditions. In terms of the outcomes which the negotiations produced, there were several examples of improvements over the national agreements, but this involved a highly uneven distribution of benefits.

The attentions of the unions now turned to the individual representation of members affected by the new system, a role with which the majority were much more familiar. Having reached agreements on all of the major substantive issues involved, the process of placing individual staff within the new structure proceeded relatively smoothly.

Could the outcome have been any different? In addressing this question it has to be recognised that the unions would have faced a major difficulty had they had sought to utilise the stance taken by cooks to delay progress on implementation

until the concerns of all staff had been fully addressed. Management were prepared to concede on the payment for CPU cooks because of the recruitment problems they recognised would otherwise be faced. At the same time, a prime motive factor behind the whole system was the potential it offered for efficiency savings: recovering some of these for the benefit of staff for whom recruitment was not seen as a problem may have proved far more difficult.

To an extent the local NHS managers can be regarded as having to act on the basis of capitalist rationality, and this provided the context within which bargaining could occur. The existing gender-structuring of the workforce was then reinforced in the new structure. Nevertheless, once the unions had dropped their opposition management were willing to provide considerable support for them to participate in negotiations. It is impossible to judge whether this would have been any different had it occurred after the introduction of general management, although it is worth noting that the lead manager responsible went on to a far more successful career within it than did many of the other local administrators of the time. Although preceding it, the management style which was adopted was closer to that of general management than with its predecessor.

While it would be wrong to see these processes and outcomes as automatic it cannot be denied that the bargaining goals of the unions, largely reflecting the main sources of active involvement and support from within their memberships, reinforced the impact of other pressures such as the influence of external labour markets. Member involvement was variable throughout the negotiations, and at an early stage those principally involved were those most likely to be seeking jobs within the CPU. With new possibilities for local negotiations come many of the limits of traditional collective bargaining, particularly its frequently highly sectional character.

Nevertheless, in the context of renewed efficiency drives within the NHS it may offer an important model for the future. Before considering how general its

application may be the following provides an alternative account of changes to conditions of employment brought about under the same financial pressures. Despite this similarity, both the processes and outcomes to which it gave rise were to be considerably different from the experience in the catering service.

Efficiency, staffing and labour costs: the case of nursing

This section describes experiences arising from management attempts to change nurse work rotas in the general hospitals. It is a shorter account than the preceding one largely because there was far less in the way of structured negotiations around specific bargaining objectives. Related to this, and perhaps representing the most important difference, the distinction between phases of opposition to the change and negotiations over the terms of its introduction were less clear cut. The cook chill catering system had been introduced prior to general management, in contrast, the teeth of the new general managers were cut in changing nurse work rotas. Yet the origins of the change lay in an earlier and very different source.

Nurse staffing levels in local hospitals had been considerably below those regarded as necessary for much of the 1970's. This was a view taken not only by the unions and by 1979, as was noted in Chapter Five, temporary ward closures were being announced as a consequence. By the following year the implementation of the Clegg award for nurses, with its reduction in the working week from forty to thirty seven and one half hours, put further pressure on the system. Complaints about levels of staffing continued.

In 1984 the Health Authority appeared to accede to these claims in a decision to commission an independent report into levels of nurse staffing within the Dis-

trict. Several methods of measuring nurse staffing levels have been developed and nurse managers and staff organisations were apparently involved in the selection of the method to be adopted. The system that was chosen was one known as the "Telford" method, a system which makes considerable use of the perceptions of required staffing levels by nurses themselves. The study was protracted as it involved visits to all wards, and discussions with individual members of the nursing staff on levels of nursing activity and their perceptions of need.

When the report was published it concluded that levels of nurse staffing were substantially below that which was required, by over three hundred throughout the District. This appeared to confirm the claims which had long been made by the nursing unions, by many nurse managers and indeed by several hospital administrators themselves. However, by now the era of efficiency savings had arrived. In this context there was little likelihood that the Health Authority would find the resources necessary for such an expansion.

Instead, the initial response from the Health Authority involved a criticism of the methods of the Telford study on the grounds that it was too subjective. The unions were able to counter this with the response that it was the Authority itself which had originally commissioned the report and its method, and it was rather late in the day to question its legitimacy. These however had more the character of debating points in the context of very real financial constraint. Meetings were held with the unions, on one occasion very unusually attended by Health Authority members themselves, to consider what action to take in light of the report's recommendations, but very little was done in the short term. In effect, whether by intention or otherwise, the problem remained one for the incoming general management to pick up.

This brought with it a very different approach to the problem. By 1986 the management were arguing that the problem was not one of there being too few

nurses but rather that existing ones were being ineffectively employed. The focus of attention was shifted to the afternoon "overlap" period between the early and late shifts, which it was claimed was too long. Cutting this overlap would allow the morning duty to start earlier and the late duty to finish later, with a further consequence of a shorter night duty. This in turn would mean fewer night staff would be needed, or, as was proposed, the same number of night staff would work more but shorter shifts. On average this would mean one extra night duty per fortnight. Not only did this solution reduce the claim for extra nurses, it did so in a way which made the largest contribution to the Authority's efficiency savings second only to the introduction of the cook chill catering system.

From the outset, the unions adopted a policy of outright opposition to the proposal. Arguments were put forward that the overlap was a necessary period in which the slightly more generous level of staffing enabled a variety of tasks to be completed. For this some evidence was used from nursing research literature, but this type of "professional" argument was not to the fore. Two possible reasons for this are worth noting, firstly concerning the role of nurse managers, and secondly the nature of pressure from members themselves.

The period was one in which nurse managers were still establishing their relationship with general management. As was mentioned in Chapter Five, one Director of Nurse Services, an active RCN member, had already resigned in protest at what he saw as unacceptable levels of resources for nursing. Few others would be prepared or able to adopt such a course even had they desired to do so. This meant they had to negotiate a relationship with general managers which recognised the new sources of authority.

The second factor concerned the response from nursing staff themselves. This tended to emphasise the impact the changes would have upon their existing conditions of employment. For example, many day staff objected to proposed rotas

which could mean finishing work at 10.00pm one night and starting again at 7.30am the following morning. However, the strongest resistance came from night staff who objected to working the extra night for the same level of pay.

These two factors combined to create most emphasis being placed upon the impact of the change on conditions of employment. This however created a potential difficulty for the unions in maintaining their opposition to the plan. Although this had the apparent support of members, with conditions of employment issues to the fore it became inevitable that pressures would arise to negotiate over the terms of change. This was in fact how management responded, signalling their intention to proceed with implementation of the changes while being prepared to negotiate its introduction.

The unions entered into talks with management without renouncing their opposition to the intentions, as had effectively been the case with cook-chill. A consequence was that management did not appear to regard this as a serious intention to negotiate around the principle of the change. In any event, little emerged from the talks in the way of mutual agreement.

At this point the tactics being adopted by management began to change. Whereas with cook-chill a willingness had been shown to hold back until key aspects had been negotiated, management now announced their intention to implement the change regardless of agreement with the unions. This was a very real departure from any previous practice and no doubt reflected managerial intention to secure the perceived available savings. The announcement was accompanied by a new tactic of approaching individual members of staff to accept the change in working hours.

It is impossible to judge precisely what happened but there were numerous complaints of intimidation by managers of individual staff. Certainly many individual nurses have expressed the view that they felt pressurised by management to

accept the changes. This included some instances when individuals reported that they had been told that refusal to accept the changes could result in their dismissal. It was certainly the case that on several occasions staff were interviewed by managers without the presence of a union representative. Management denied that this was their intention, but there nevertheless appeared to be at least some occasions when managers arrived at unusual times during the night and interviewed staff when no representative was available. The issue created considerable anger, and led to an explicit management statement that all staff had the right to be accompanied by a union representative if this was their wish.

By this time some individuals had agreed to accept the changes, and although the unions argued this had been under duress this did not alter the fact that acceptance of the changes had gained a foothold. This situation gave rise to a period of some recrimination and conflict within and between the unions. From many members came criticisms of the unions for their lack of assistance, while several union representatives expressed their frustration that individual members were pressurised into accepting the change. These problems were compounded by the genuine communication problems which existed as several hospitals across different sites were involved involving a work-group providing a round-the-clock service.

The level of membership involvement was rising, particularly as measured by attendance at meetings to discuss the issue, but this was by now at a relatively late stage. In this climate some nursing staff sought advice outside of the unions by going to local solicitors. Unsurprisingly they received a legalistic interpretation of employer's abilities to alter individual contracts of employment, and the difficulties faced by individuals resisting this.

The role of the nurse managers had become a significant issue. They were major actors in the process and their role created considerable anger among many union representatives. Several expressed a feeling of betrayal by nurse managers

with whom they felt good working relationships had previously existed. Others stated they experienced a different relationship with nurse managers during this period even though in many cases they had known them for several years. Comments were made that many nurse managers were seen to be doing the "dirty work" for general managers in trying to get the plan implemented. This had particular relevance in the context of union attempts to argue the potential clinical disadvantages of the change which was felt to be undermined by the stance taken by nurse management. Similar in some ways with the issue of food hygiene in relation to cook-chill, "professional" objections proved harder to sustain in the absence of support from what might be seen as legitimate authorities. What made this case rather different was a greater expectation that such support would be forthcoming.

In what was becoming an increasingly chaotic situation a further problem emerged for the majority of unions. This was still at the time when the TUC unions were meeting management separately, and it now became evident that the RCN were already engaged in talks with management. The division between the TUC unions and non-affiliates had not been an issue with the catering staff, but here it created additional problems in what was already a confusing situation. Further to this, unlike the situation in the catering service where the GMB had been dominant, nursing union stewards and full-time officers were generally not so enthusiastic or comfortable with more localised bargaining.

Nevertheless, a local agreement was finally reached by the JTUNC and management which, as in the case with catering staff, went outside of provisions within the Whitley Council national agreements. It was wholly related to providing a compensation payment in return for staff acceptance of the change, with payment being based upon flat rate payments of £200 for unqualified staff and £400 for qualified staff together with supplements for service of five years or over and for night staff.

The range of total individual compensation payments was between £200 and £1,000, although it is worth noting that the agreement provided slightly better terms for qualified compared to unqualified staff, as in the differential flat-rate payment. For the Authority the total cost of the compensation package was estimated to come to £352,300. While this was a substantial sum it had to be set against the ongoing savings the changes were expected to secure.

Even with this agreement, some groups of staff refused to accept the change. However, this left them in the position whereby any future job move would require them to accept the change but without any compensation payment. Although the number of groups refusing was relatively small, they did indicate that in the face of refusal there was little in the way of counter sanction that management possessed. Whatever suggestions of dismissal may have been made, it would have been inconceivable for a Health Authority to sack virtually its entire nursing workforce.

The potential basis for resistance would appear to have been far stronger on this issue than had been the case for cook-chill yet this did not on the whole materialise. Of greatest significance in this was the character of union organisation and the role of nurse managers. The two were closely related as the episode marked a period of transition in which nursing became subject to the scrutiny of the new managerialism in a way that it had not hitherto. As the example of the seeking of legal advice illustrated, many nurse union members did not demonstrate the same reliance upon collective action as had the cooks who refused to apply for posts within the new catering service until agreements had been reached. Deficiencies in union organisation and communication reflected, rather than caused, this lack of collective identity.

In tackling the organisation of nurse work rotas, general management showed itself to be increasingly acting "as if" capitalists and, in many respects more significantly, nurse managers found themselves accepting the same logic if resources

were to be released for the services they deemed necessary. In this situation the unions were unable to sustain an effective collective response. The final bargained outcome, compensation for the terms of change, suggested increasingly similarities with the situation facing ancillary workers. A major difference had been that the unions had not been provided with the same measure of institutional support from management as had been the case in the catering service. This reflected the fact that there the principle of change had been accepted and attention could turn to the terms of its implementation.

Opportunities and limitations in local bargaining and representation

Before leaving these examples of responses from unions where outcomes involved negotiated arrangements over the terms of change, two general points can be emphasised. These relate to the new opportunities which managerial changes created for local bargaining and the limits under which this existed. Processes in each case were fundamentally shaped by definitions of union purpose and the objectives these were designed to secure: ultimately these were shown to be the protection of terms and conditions of employment. New opportunities for their more localised determination were evident in each of the changes, yet the outcomes to which they gave rise were highly uneven both between and within the two groups.

In appearing to reduce the distinctiveness of NHS industrial relations many of the more generally experienced characteristics of collective bargaining came to be felt. Above all this included the sectional differences it can contribute towards. The particular pattern they took in these cases reflected a variety of influences in which a crucial role was the character of union organisation, in terms of the nature of collective identity and the form of its relations with sections within management. The

episodes nevertheless suggested the possibility that an increasingly bargaining-based strategy, in the changing context of the NHS, requires a willingness to accommodate with general management in certain of its objectives.

These two episodes can in this sense be seen as illustrative of a "new realist" approach, but as such also indicate the difficulties of converting a tactical response into an overall strategy. This became increasingly evident in the period following the introduction of cook chill in 1984 and the changes to nurses hours in 1986. Growing difficulties were experienced by the Health Authority in identifying further scope for efficiency savings and the Authority observed:

> It is generally accepted that the cost improvement schemes which are relatively more straightforward in management terms to implement have already been dealt with satisfactorily within this District. (Plymouth Health Authority, Annual Programme 1990/91).

Despite this, the Plan is forced to acknowledge:

> It is likely that in future years the only source of finance for developing services will be that which can be generated internally from reviewing existing services. (Plymouth Health Authority, Annual Programme 1990/91).

By that time only £507,000 of a cost improvement target of £924,000 for 1990/91 had been positively identified, and the Authority imposed a one per cent levy on pay budgets by increasing the vacancy/staff turnover factor. This was a straightforward cut, producing an anticipated saving of £800,000, rather than a genuine efficiency improvement. A consequence of this renewed financial stringency came in further evidence of divergence between staff groups, which can be briefly illustrated by returning to the example of the new bonus arrangements which had been agreed for those catering staff not working in the CPU.

In subsequent negotiations surrounding competitive tendering the formula which had been reached for catering assistants, based upon the achievement of

additional savings from within the catering budget, had been extended to apply also to domestic assistants. This was to create considerable variations within this group of staff. For example, in 1989/90 the in-house hotel services contract (including domestic and housekeeping services) at Plymouth General Hospital was underspent by £23,745, mainly attributable to the reduced consumption of materials, while that at Derriford was overspent. The new bonus agreement meant that £17,000 was divided among staff at Plymouth General in bonus payments while staff at Derriford received no bonus payment. Although some Health Authority members were suggesting that the bonus arrangements be scrapped altogether to increase savings, this was resisted by managers who clearly saw them as having been an important factor in achieving consent.

While this attitude illustrates the potential for a more market-based bargaining strategy, the uneven impact which it had and the variable extent to which it was embraced by different groups of members suggest other difficulties. The group which demonstrated the strongest, and most successful, commitment to a bargaining strategy, the cooks in the larger hospitals, were predominantly male. In contrast, most other staff, including catering assistants, cooks in the smaller hospitals, and the majority of nursing staff, were female. Although the more unionate bargaining strategy appeared more effective in protecting job interests an important factor in this was the scale of savings which management were determined to achieve.

Two possible interpretations might be placed upon these outcomes. The first is to emphasise the possibilities localised bargaining create for achieving benefits for members which, however limited and uneven in their distribution, nevertheless represented a real improvement upon that which would otherwise have been available. In these terms it represented a necessary and rational accommodation with the new realities of health service management. The second is to focus upon the limita-

tions which market-bargaining possesses in extending and deepening divisions within the workforce.

However, the obstacles which union opposition faced were not exclusively the product of managerial intent to secure efficiency savings. This determination was matched by an inability on the part of the unions to secure sufficient "legitimacy" for their own opposition. Such legitimacy would seem most likely to arise where issues were directly concerned with matters of service provision and where staff were able to claim some degree of 'professional status'. To explore these possibilities further the following chapter looks at examples where management sought to alter planned developments in mental illness and mental handicap services and the implications this had for service delivery and employment.

These examples provide an opportunity to consider whether the relationship between bargaining objectives and service issues can be different to that which was identified in the issues considered here. They offer a means of assessing how realistic it is to expect unions, "to address the content and objectives of their members' work, not just the terms and conditions" (Clay, 1987, p143). In particular, they can be used to consider whether 'professional' strategies rather than 'market unionism' might prove more suited to some work groups within the health service.

CHAPTER SEVEN

BARGAINING AND PROFESSIONAL STRATEGIES

In the episodes described in the previous chapter unions were unsuccessful in resisting the implementation of change designed to raise efficiency and labour productivity. Both episodes were ones in which management proved capable of claiming that the proposed changes would be able to deliver the same outputs as before, but requiring fewer inputs. This weakened the basis of union resistance and encouraged attempts to negotiate over the terms of change. The fact that the outcomes of these were variable, in large part reflecting the character of union organisation and the nature of alliances it was able to form with sections of management, was noted. Where these were based upon older relationships, as was the case with nursing, these seemed less durable than was the case with newer forms of accommodation with general managers. These seemed prepared to support a new bargaining relationship founded upon an implicit acceptance of management's "right to manage".

A question which this raises is whether or not the same would apply in the context of changes designed to secure a change in outputs as well as inputs. In terms of the health service as a producer of use values, would this create greater opportunities for unions to influence the broader direction of change beyond its impact upon pay and conditions?

In Chapter Two reference was made to a strategy of trade unionism which emphasised professional objectives, with it's status as such, rather than as an example of extended collective bargaining, being implicitly based upon claims to specialist expertise and knowledge. Without entering the wider debates here concerning the notion of professionalism it can be treated as a particular strategy for gaining occupational control and as such possesses something in the way of a distinct

identity. The two examples in the previous chapter suggested very minimal opportunities for union involvement in job content where major pressures for change were operating, and the discussion in this chapter develops a rather different direction by looking at possible scope for union influence in the planning of service delivery and related employment matters. This is designed to explore two issues: the extent to which health care retains a distinctiveness irrespective of a tendency for the labour process to become increasingly analogous with that of a capitalist enterprise, and how far staff claiming professional status may be more successful in countering such a shift.

This chapter examines managerial intentions to alter agreed service development plans in services for the mentally ill and mentally handicapped, with the discussion structured around separate treatment of the two services. However, it is useful to introduce this with a very brief summary of their background for although the two services developed very differently historically they were each to become subject to policies designed to transfer care into the community. Of more significance still for the current discussion, these policies were to be implemented in a period of severe financial constraint.

Local services for the mentally handicapped developed late in Plymouth. The origins of this lay in the nineteenth century with the building of an asylum at Starcross near Exeter, the Royal Western Counties Hospital. This was for patients from throughout Devon and Cornwall, and it provided most of the NHS facilities in the two counties until its closure in 1985. The development of Plymouth NHS facilities did not begin until 1978. In 1979 a plan was agreed by the then Devon Area Health Authority which envisaged local NHS provision of one-hundred residential places and forty additional day places by the end of the 1980's. These were to be provided in four community units, and towards this objective two community homes were opened in 1981 with forty residential and twenty-five day places being provided by

1983. By this time local NHS managers in Exeter were accelerating plans for the closure of Starcross. Interestingly, this was to give rise to very different developments in Plymouth and in Exeter. Discussion in this chapter focuses upon the former, although some comparisons with Exeter are drawn in the final chapter.

Plymouth services for the mentally ill have traditionally been based at Moorhaven Hospital, situated on the edge of Dartmoor ten miles from the city. Development of community-based services started as far back as 1957, at a time when there were over eight hundred patients in the hospital. This figure had been reduced to five hundred and fifty four in 1977. By the late 1980's less than two hundred patients were accommodated at the hospital, and closure is planned by 1993.

In each of the services there were relatively long-standing plans to replace traditional institutional care with services based in the community. A significant difference was that for mental handicap services the original time-scale for service developments was altered by decisions by Exeter Health Authority. An important factor held in common by both services, and which was to prove of crucial significance, were policy decisions by Plymouth Health Authority that service development was to be contained within the levels of existing spending on the services. In relation to mental handicap services, this was the stated intention of Plymouth Health Authority at least as far back as 1983:

> The cost of replacing the existing service for Mentally Handicapped people with a community based service is intended to be self-financing. That is, the costs of the new service should not be greater than the cost of the current service (PHA District Treasurer's Office, November 1983).

Similarly, on proposals for services for the mentally ill it was stated in the following year:

> The plan is self financing in revenue which will be provided from the rundown of services at Moorhaven while capital will be provided by deferring large upgrading schemes which were

> planned for Moorhaven Hospital (PHA Strategic Plan, 1985-94).

These financial objectives, arguably above all else, shaped both future service development and the nature of conflict with the trade unions. Two points are noteworthy here. Firstly, this policy preceded the introduction of general management; the influential factor was the pressure of financial constraint. Secondly, it was a policy which was shortly to come under fire from the House of Commons Select Committee on Social Services which protested:

> A decent community-based service for mentally ill or mentally handicapped people cannot be provided at the same overall cost as present services. The proposition that community care could be cost-neutral is untenable. . . . Proceeding with a policy of community care on a cost-neutral assumption is not simply naive: it is positively inhumane. (House of Commons Select Committee on Social Services, January 1985).

Yet this was precisely what Plymouth Health Authority was seeking to achieve. Before long it became apparent that one consequence would be a revision of earlier service development plans. The following explains two aspects of this; firstly, on the impact of proposals to delay the implementation of elements of the plan for mental illness services, and secondly, a more fundamental reconsideration of the direction to be taken in mental handicap services. Discussion on the former begins with an account identifying aspects of the social relations on the wards as these formed an important element in the local negotiation of order.

Defending jobs and services: mental illness services

Work relations on the wards

Mental illness services at Moorhaven are divided into three sectors; acute psychiatry, rehabilitation and elderly care. The following discussion concentrates on the first two of these; acute services being broadly defined as catering for people with an immediate onset of a serious psychiatric disorder, and rehabilitation providing for those who are not experiencing such a crisis but are considered to need ongoing clinical intervention and support. In practice the difference may not be so clear-cut as this distinction implies.

Though located within the same hospital the two services differed considerably in character. On entering the respective wards the most immediately visible difference was that staff working in rehabilitation were not required to wear uniform, although this was expected of female staff in acute services (a policy which was subsequently changed). This distinction nevertheless symbolised an underlying difference in conceptions of the relationship between nurses and patients. In turn it became apparent that this reflected what might be regarded as broader ideological differences between the senior medical and nursing staff in the two sectors.

In the case of acute services this could be described as being "orthodox", with a more "challenging" model being proposed within rehabilitation. To this extent the hospital provided confirmation of Strauss's (1963) original account of the negotiation of order within a psychiatric hospital. Differences between the two sectors, while not being absolutely clear cut, were important in shaping future developments.

Within the rehabilitation service a new senior nurse had been appointed in 1983 who was quite young and articulate, and strongly committed to a new style of

community-based psychiatric service. Around the same time a consultant was appointed, also young and willing to be innovative. When nursing vacancies arose the senior nurse appeared keen to appoint, and later promote, younger and enthusiastic staff. In contrast, the senior nurse within the acute service, who was in his fifties, could be better described as being part of the "old school". A similar description could be applied to the acute service consultant; in fact the eventual removal of the requirement to wear uniform came only when a new consultant was appointed.

The developing rehabilitation service aimed to be flexible in its approach. Its stated policy objective was to base service provision upon an assessment of individual needs, requiring a range of staff to work together on a multi-disciplinary basis. A further aspect of this was a redrawing of some traditional work routines, one example of which was an agreement reached on staff duty rotas allowing "internal rotation", (that is, the working of mixed duties of nights and days instead of one or the other). This agreement was reached informally with staff in the service rather than being arrived at through the formal negotiating mechanisms described earlier.

A more traditional model of work relations was evident within the acute service. For example, one student nurse who had experienced work on both acute and rehabilitation wards remarked that nursing staff on the former appeared to be more subservient to medical staff. There were occasional exceptions, as when a deputy Charge Nurse objected to the diagnosis of someone as mentally ill by a junior doctor to be over-ruled with the words, "Well I'm saying he is". During a discussion of this episode some nurses on the ward expressed resentment that a junior doctor, with possibly six weeks training in psychiatry, could over-rule a nurse with over a decade of relevant training and experience. However, this discussion appeared not to be taken any further: there did not seem to be a belief that their nurse management would take up such concerns.

In fact, those nursing staff who seemed most dissatisfied with subservience to doctors also seemed most critical of their own nurse management. The deputy Charge Nurse referred to above later resigned feeling aggrieved that he was not being given promotion opportunities despite being more highly qualified and experienced than some who were.

The comparison of the two services, and the nature of nursing within them, suggests the influence of senior medical staff is of considerable importance in setting the context for styles of nursing practice. In turn, senior nurse managers were able to take opportunities for innovation or to accommodate to the *status quo*. An important consequence of the differences which were evident between the two sectors was that staff, despite the fact that they worked in the same hospital, seemed to hold little in the way of a shared sense of identity. This provided the context for the impact in early 1989 of funding pressures within mental illness services.

Threats to service developments

One consequence of these financial pressures was a decision in March 1989 by the Health Authority's Mental Health Implementation Group to freeze nurse staffing levels within the rehabilitation service at eighty one whole time equivalent's. This meant that a further nine WTE posts which were needed during 1989/90 were not to be filled until resources were identified.

The senior nurse within rehabilitation believed that without these additional posts it would not be possible to proceed with the original service plan, claiming that one of three options were available until the extra posts were funded. Firstly, to stop all referrals to the rehabilitation service; secondly, to redesign the planned residential service; or thirdly, to return to a service based on residential care. He argued that the latter, other considerations apart, could ultimately prove more expensive.

Details of management discussions were leaked, with the suspicion among many managers that the senior nurse was responsible. Within a week a joint meeting of all nursing members in the rehabilitation service was organised by COHSE and the RCN. A genuinely strong sense of feeling existed, which in some respects seems out of proportion to what was actually being proposed which involved no immediate job cuts. The strength of feeling among the nursing staff must largely be attributed to a view that the future development of a community-based service might be in danger. So far as jobs were concerned, it was the defence of future ones rather than the protection of existing ones that was at issue.

Formal negotiations with general management now brought into play the informal agreement which had been reached with the senior nurse on flexible working. While this had been introduced principally on grounds of service need, it also produced some financial savings. Staff now threatened to withdraw from their informal agreements on flexible working unless the additional funding was provided for the development of the service as originally planned. The Unit General Manager was informed by the COHSE full-time officer that unless this occurred the withdrawal from the flexible working agreement would commence on Tuesday 4th April.

Shortly before this date a meeting was convened between the Unit General Manager, the COHSE Full Time Officer and the Branch Secretary, details of which were reported to a further COHSE/RCN members meeting held on the evening of 3rd April. For reasons which remain slightly unclear, but apparently relate to a perceived opportunity for further negotiations, the meeting agreed to suspend the withdrawal from flexible working for two weeks pending further discussion. A further letter was then sent to the Unit General Manager, again in the name of the COHSE Full Time Officer, seeking a commitment from management on the following points: firstly, 87.09 WTE nursing posts to be fully funded from 5th April 1989;

secondly, 96.0 WTE nursing posts to be fully funded from 5th April 1990; thirdly, for the final plans for the rehabilitation service to go ahead as agreed; and fourthly, for the rehabilitation service to stay within the NHS.

The reply from the Unit General Manager gave a clear commitment on the first of these, although this included two converted domestic posts which, it was stated, had the agreement of the senior nurse. No such guarantee was forthcoming in respect of the additional posts for 1990 on the grounds that the amount of growth money was at that stage unknown. On the final plans for the service, the Unit General Manager remarked that there seemed to be some confusion as to what these might be, suggesting that COHSE and the RCN indicate how its members interpreted them. Finally, the Unit General Manager was not prepared to guarantee that the rehabilitation service would stay within the NHS, pointing out that the Government's response to the Griffiths report on care in the community could alter existing arrangements.

While the reply fell considerably short of what had been sought it had gone some way to reducing the original causes of anxiety. As this occurred in the context of very tight NHS financial constraint at this time, mid-1989, the staff protests can be regarded as achieving some success. That two of the additional nursing posts were to be funded in effect by reducing domestic staff posts was deemed acceptable indicates the boundaries between the two groups of staff as well as the fact that protests were founded upon issues relating to the quality of nursing services.

In negotiating terms it might be felt that at this point the unions should have grasped the concession offered by management. What in fact appeared to develop was a growing confusion over what objectives were being pursued. When the contents of the Unit General Manager's reply were conveyed to staff a view seemed to prevail that further discussion was warranted to try and gain some extra ground. However, talks at a subsequent meeting of union representatives appeared to make

little progress in terms of what direction this should take. There then followed a period of apparent inactivity while other options were being followed up by the unions, including an unsuccessful appeal to the Chairman of the South West Regional Health Authority for the management of the services to be subject to external review.

This in fact had been sought by the senior nurse in rehabilitation, who claimed to have been continuously frustrated by higher management in his implementation of service developments. Events however took a new turn in early July when he announced his resignation from the Health Authority. This decision was justified by what he described in an interview as recurring uncertainty over funding and a management structure which was insufficiently representative of practitioners. He also attracted considerable local media publicity for claims that he had unsuccessfully attempted to negotiate with the Authority for adequate resources over several years. The context had now changed substantially, with public accusation and counter-accusation flying between the Authority and its former senior nurse, broadening out from the original issues to include several allegations concerning sensitive aspects of patient care.

By now, several staff working in rehabilitation were concerned about the effect the publicity might be having on patients and their families. COHSE, and particularly its full-time officer, had also been closely associated with the publicity. The Divisional Nursing Manager for mental health, a COHSE member for very many years, resigned from the union, amid suggestions that others might be doing the same. She now found herself protective of the general management against the claims being made by the former senior nurse. This was one aspect of a broader deterioration in relations between the COHSE Full Time Officer and Health Authority senior managers during this period. The situation caused considerable concern for several lay representatives, particularly the Branch secretary who

expressed a fear that this was compounding local communication problems which were seen as existing within COHSE itself.

Throughout what had become an increasingly acrimonious and public dispute, the RCN maintained a far lower public profile, referring instead to the preparation of a case to present to the United Kingdom Central Council (UKCC), responsible for professional matters. Some nurses appeared to prefer this approach, and this may have been a factor attracting them to the RCN. An attempt to bring nursing staff together again was made in the calling of a further joint meeting of members in July, where discussion took place on the need for staff to be involved in drawing up the future plans for the service and not leaving it as a management activity.

Having resisted acceptance of the original offer from management this was logically the only direction left to take. Yet one of the most interesting parts of the discussion were comments expressed particularly by the RCN Full Time Officer, who was the former Plymouth nursing manager who had resigned over spending restrictions, that the unions should not do this but instead leave it to the nursing team leaders. This division of responsibility was justified on the grounds that as professional staff they would possess the necessary "credibility" for such a task. The view appeared to gain some resonance among many of the staff who were present, indicating a fear that to identify the unions too closely and directly with "professional issues" might have the effect of undermining the arguments.

After all, where jobs and employment conditions had been to the fore, as with the issues discussed in the previous chapter, the unions had during their period of opposition been accused of hiding behind claims about food hygiene and patient care. It was also interesting to note in the current context the perception that the team leaders were seen as representatives of the staff rather than of management.

There was a further element to this delegation of service delivery issues to those in positions of management, which can be illustrated by reference to a discus-

sion at a COHSE meeting called to discuss the issue. This was also attended by the Full Time Officer and the senior nurse who had resigned. At one point, the FTO was making some general comments about those who performed the work generally knew most about it, at which point he paused and a female Enrolled Nurse joined in to continue in terms of the need for staff to be involved in decisions. The FTO then interrupted, turning to the former senior nurse for his views.

The widening of the issues involved in this case created some uncertainty within the unions, and rather different responses from COHSE and the RCN. The more active COHSE representatives felt that the RCN was deliberately seeking to use the opportunity for recruitment by adopting a lower-profile and, in the words of one, "sent COHSE over the top". If this were the case, the tactics taken by COHSE had been largely shaped by those of the former senior nurse. In this there was relatively little in the way of internal debate as to whether this was the appropriate action for the union to adopt. The union had been drawn into a dispute which originated in a conflict between general management and a section of the nurse management.

Ultimately little happened to resolve the situation decisively. A later call to renew the threat to withdraw from flexible working arrangements no longer received the support from staff it had earlier. The departure of the senior nurse, despite highlighting concerns in the short term, had in a small but potentially significant way altered the local negotiation of order. The RCN appeared to gain some support for the style which it adopted of seeking to support and advise in a process of indirect staff involvement in service planning. It is a style in which legitimacy is founded upon individual professional expertise, and not necessarily in the collective knowledge of members.

The apparent failure of COHSE to achieve greater staff involvement in service planning has also to be understood in the context of what was said earlier about

relationships between staff in rehabilitation and the acute sector. Some staff working in the latter appear to regard the difficulties within rehabilitation as exaggerated. Several expressed the view that problems of uncertainty and underfunding existed just as much within acute wards.

For example, since at least the early 1980's plans have existed to transfer acute psychiatric beds from Moorhaven Hospitals to Derriford General Hospital, and in Plymouth Health Authority's Annual Programme for 1985/86 the date for this was set at March 1985. This was later postponed and a new date of transfer set for 1986/87. Later still the opening date was again set back to 1992, a date which was finally achieved. While this did create uncertainty it has also to be noted that several staff appeared more content to stay with existing services than was the case among staff in rehabilitation services.

Of greater importance as a source of grievance in the acute services was an alleged shortage of staff. The impression was also given by some acute staff that they considered their own work experiences with people having serious disorders as being particularly demanding, or in the words of one, "absolutely knackering". Whatever the relative difficulties faced by staff in the two sectors, complaints about low staffing levels in acute services did receive some confirmation. In May 1989, around the very time when issues in rehabilitation were coming to the fore, a consultant psychiatrist wrote to the divisional nursing manager for mental illness services to say:

> I am writing to you because of my extreme concern about the risk to staff and patients on Moorfields Ward (an acute ward). Due to inadequate levels of nursing staff the quality of care available to patients has been low for some time. (internal correspondence).

The consultant added her view that patients were becoming more disturbed as a result of receiving minimal attention:

> This increases the stress on staff, which is exacerbated by the hours of overtime they need to work to maintain a minimal staffing level. (*ibid*).

It was perhaps unsurprising that this should have arisen around the same time, as it was a period of widespread pressure on health spending. What is more notable is the lack of joint activity between the two sectors which this situation provoked. If anything it seemed to reinforce existing divisions. Issues within rehabilitation had come to a head as a result of conflict within management in that sector, but this had not emerged within the acute services.

A lack of common identity between the two groups of nursing staff was an obstacle in the way of generalising the issue of staff shortages and improvements in service delivery. Added to this was an uncertainty demonstrated by the unions in their objectives, linked to a hesitation in taking a high profile on what were deemed to be "professional" issues. The tactic of calling for an independent review of management at the hospital had been intended to obviate this problem but this proved unsuccessful.

Ironically, just such an inquiry was held two years after the events described here, conducted by the Health Advisory Service, a body originally established in the wake of 1960's inquiries into psychiatric hospitals. In many respects the report appeared to confirm the views which had been earlier expressed by staff and their unions. The report's opening words highlighted the context of managerial change, claiming:

> General management has a significant task to perform in overcoming the negative attitudes held by many professional groups towards its concept. . . Attention should be focused on the style and practice of general management so that it is able to provide the leadership and inspiration necessary to secure the active partnership and commitment of practitioners. (NHS Advisory Service, 1991).

Comments in the report on the rehabilitation service were generally positive, particularly in terms of the role of staff. It was described as having a, "well thought out philosophy", and, "the enthusiasm and commitment of most of the staff is commendable . . . and have adapted well to the new settings in which they work." Criticism was reserved for some aspects of the way in which the service was developing, particularly concerning the resources available. Specifically the report expressed concern whether bed numbers had been reduced to "below the minimal survival level".

Some of the harshest criticism was however reserved for features of the acute service, illustrated in the following extracts:

> staff are trying to maintain a service in very difficult circumstances. Some of the conditions are unacceptably poor . . . The appearance of Moorfields Ward is grim and drab . . the building is in a poor state . . . toilet facilities are inadequate. . . Drake Ward has limited facilities. (*ibid*).

Overall the report noted a, "strong sense of the need for urgent improvements", emphasising what it saw as problems over staffing levels, particularly where more severely disturbed patients were concerned. Despite the fact that the report provided independent confirmation of many of the complaints which had earlier been made, by the time of its publication the situation was very different. The management of the community services unit, within which mental health services were located, were now submitting an application to secure Trust status.

An important element in the advantages claimed for this move was that the services had been inadequately resourced under previous arrangements where general hospitals had dominated. Nurse managers gave their support to this view, to the extent of writing to every member of the nursing staff expressing their support for the application. Only the small group of medical consultants appeared to resist the proposal.

However, when COHSE put the question of Trust status in a ballot of members it was overwhelmingly rejected, indicating how far the distance had become between many nurses and their managers. The latter were increasingly being seen, as had earlier been the case in the general hospitals over the changes in rotas, as the "agents" of general management. The two years from 1989 to 1991 demonstrated a remarkable shift in alliances. The period had started with the senior nurse and consultant in rehabilitation expressing joint concern about changes, and the consultant in acute writing directly to the divisional nurse manager to express dissatisfaction over staffing levels. Two years later, general and nursing managers were jointly advancing a strategy for Trust status in the face of opposition from consultants and the majority of nursing staff.

This emergent coalition, evident in an early form at the time when the senior nurse in rehabilitation announced his resignation, reflected a changing managerial context. However, earlier divisions within nurse management, staff and unions cannot be ignored. Staff had been structured, not so much by capital as by alternative identities and ideologies of psychiatric nursing, which were reinforced by separate nurse management systems. The unions were to be shown very much as secondary organisers in this situation, ultimately unable to generalise what in many respects were common experiences.

The possibility cannot be ruled out that such divisions may prove less durable than those arising through structural relations created within capitalist exchange relations. Whether the mutual production of use values can be a source of overcoming sectional divisions is discussed in terms of mental handicap services. These provide a different opportunity to consider ways in which staff and unions sought to constrain financially driven managerial objectives.

Resisting Private Provision in the Mental Handicap Services

Proposed Reductions in NHS Provision

The background to these events lay in the transfer of services to Plymouth. A significant change in the direction of policy intentions occurred in 1984 with the production of a joint strategic plan for mental handicap services by Plymouth Health Authority and West Devon Social Services. This proposed that the NHS cease to provide residential facilities, with the exception of a twenty-bed short term treatment unit, to concentrate instead on the provision of community services. Responsibility for implementation of the plan was vested with a Joint Management Group (JMG), representing the Health Authority and Social Services.

COHSE regarded the proposals with considerable concern. The union asserted that its arguments were based on the interests of the users of the service, although it was accused of seeking to safeguard its own members' jobs first and foremost. Unlike the situation in rehabilitation, where members were committed to the development of NHS community based services, the issue in the mental handicap sector revolved principally around the respective contributions of the NHS and the private and voluntary sector.

At an early stage, COHSE won some support from management for its claim that a twenty-bed NHS provision being proposed would be inadequate. In March 1984 the District Management Team stated in a report subsequently endorsed by the Health Authority:

> The DMT questions whether the twenty beds listed in the plan will be adequate for the long-term NHS provision, it was impressed with the COHSE submission on this point. (PHA Mental Handicap Strategy paper, 1984).

The relative contribution to be made by the NHS and the private and voluntary sectors shaped the character of much subsequent debate, with a major element in the Health Authority/Social Services joint strategic plan being a substantially increased role for the latter groups. An account of the closure of Starcross has noted:

> The major trades union involved seems generally satisfied at the levels of care which are being maintained, with the exception of patients due to return to the Plymouth district (Radford and Phillips, 1985, p23).

The writers comment on the contrasting ratio of NHS, social services, private and voluntary sector provision in the different District Health Authorities in Devon and Cornwall. Exeter proposed by far the greatest NHS provision while Plymouth had much the greatest private and voluntary sector contribution. An important factor in this was again the pressure of financial resources. It was a feature which both COHSE and the Joint Trade Union Negotiating Committee had objected to strongly, particularly in the context that private provision was already greater in Plymouth in the early to mid-1980's than in many other parts of the country. Despite these objections the plans now foresaw an increasing role for the "independent" sector.

The unions were nevertheless able to protect NHS provision for the best part of a decade. In this, an important factor had been their ability to demonstrate the inability of the private and voluntary sectors to provide the levels of service required, especially in the case of those for people with more severe handicaps. Before describing the ways in which management responded to the difficulties this created for the implementation of the new plan, it is relevant to note early but unsuccessful attempts to incorporate COHSE into the planning mechanism.

From the outset, COHSE had distanced itself from the original plans and objected to the proposed composition of the Joint Management Group. The

response from management to this was to suggest nursing staff should also be represented, and offered a new seat on the JMG to the staff in addition to that already held by the senior nurse in the service. COHSE nursing stewards, who formed the most likely candidates for this seat, felt uneasy about accepting this offer. The matter was brought to a COHSE branch meeting where it was decided to reject it, a view which by all accounts appeared to have the support of members within the service. A general feeling was that acceptance would risk isolating and possibly compromising an individual representative.

However, management then responded to this rejection by offering the seat to the Joint Trade Union Negotiating Committee. This was an interesting move as initially the offer had been made to, "a member of the nursing staff", apparently signifying their professional rather than trade union role. The majority of the unions on the JTUNC viewed the offer more positively than had COHSE, and felt that it should be accepted. This reflected the fact that it coincided with a period in which the unions had been demanding more involvement in decisions taken by management. In this situation it appeared contradictory to many union representatives to reject an opportunity such as this. At one point during the meeting of the JTUNC where this was discussed, it seemed that a representative might be elected to take the seat but COHSE successfully secured a delay for the issue to be taken back to their members.

Eventually it was agreed to put forward the name of the COHSE Full Time Officer for the seat. It is doubtful whether the taking of this seat afforded any significant planning input, and events which subsequently developed were in any case to lead to the officer resigning from the JMG. The significance of it lay more in what it illustrated about the nature of alliances within the service. While the local COHSE representatives had been unwilling to accept a degree of incorporation into the management structure, four other forms of alliances were to prove crucial in

later events. These involved staff at Starcross, staff within the Plymouth service, nurse management and user's relatives.

The first of these, initially of greatest importance, arose from the Plymouth COHSE branch persuading COHSE members at Starcross Hospital not to assist in the discharge of patients to Plymouth until agreements had been reached on local services. The impact of this policy was noted in the account of the closure of Starcross referred to above, which identified the action taken by COHSE as being of particular significance in:

> stalling the discharge of patients to the Plymouth area because of what it sees as an undue reliance on private sector provision with possible concomitant reductions in the quality of care (Radford and Phillips, 1985, p32).

The impact of this blocking policy removed the possibility of a wholesale reduction of NHS provision in Plymouth, other sources of support were however needed to ensure this situation was maintained. Throughout the mid-1980's indications were coming from management that their intention remained to reduce local NHS provision, yet these were to prove equally unsuccessful. Of considerable importance in this was the alliance among staff within the Plymouth services. Union organisation in the mental handicap service was generally more effective, with better internal communication and a more active steward system, than was the case at Moorhaven. In practice this involved a relatively small number of people in terms of regular activity, but there were not the divisions which had been so evident at Moorhaven.

There were two important aspects to this. Firstly, despite the existence of distinct identities between individual NHS mental handicap units, as for example between those providing services for adults or children, there appeared to be a common service identity which crossed such boundaries. One factor in this may have been the preponderance among qualified staff of younger members, recruited to the

area to develop the new service. Secondly, the almost "single union" character of mental handicap services, where the overwhelming majority of staff were members of COHSE, avoided the situation which had emerged at Moorhaven as a consequence of rivalries and suspicions between COHSE and the RCN.

Together these created a situation in which a high level of trust and confidence appears to have existed between stewards and members, standing in some contrast to the earlier example of changing nurse rotas. This is particularly noteworthy in the context of wider debates about the impact of workplace fragmentation upon union organisation. Such fragmentation was noted to have been a problem within the general hospitals, but this was not so for mental handicap services despite the geographical dispersion of the units. One consequence of this was that, although plans for mental handicap services were probably subject to greater change than was the case with mental illness services, there did not appear to be the same degree of frustration amongst the staff. COHSE appeared better able to give a collective "voice" to individual fears and anxieties.

Closely connected with this was the third form of alliance which COHSE was able to develop, that involving nurse management. In particular, considerable trust was placed in the senior nurse within the service, with whom close formal and informal contact was maintained. Here the view was not taken that nurse management had accommodated itself with the objectives of general management. In some respects there were greater similarities with the earlier situation of the RCN in the general hospitals, with the senior nurse, who was a COHSE member himself, taking a part in union affairs including attendance at annual conferences. The link between the union and nurse management had a reciprocal effect: it both helped to sustain a collective identity among staff while simultaneously acting as a counterbalance to pressures of incorporation upon the nurse manager himself, as had been seen elsewhere.

In this connection it is also worth noting that at times COHSE took a similar view as had been expressed at Moorhaven regarding its role in advancing "professional" concerns. On one occasion the response to a set of management proposals was left entirely to charge nurses and sisters to compile on the grounds that this would give it greater professional legitimacy. The main difference between the two was that COHSE was able to adopt a far more active co-ordinating role within the mental handicap services. Nevertheless, the example illustrates the potential conflict in roles and definitions of purpose which can emerge when linkages are drawn between service provision and jobs.

The fourth form of alliance which COHSE entered was with relatives of service users themselves, which at times was to be of significant importance. Because of the nature of the service it had a relatively defined population of users and the opportunities this created may not be generalisable. Parents of children and adults with a mental handicap had particular concerns about future service provision, and in addition had come to know individual members of staff through regular contact. COHSE was able to utilise this contact to encourage the formation of a group representing users in which a number of mothers were particularly active. In interviews they expressed a high level of confidence in the nursing staff and a low level of trust in management. They engaged in several activities, including lobbying of Health Authority meetings and collecting petitions, which presented a major obstacle to management plans to reduce NHS provision.

Together these alliances considerably weakened the scope for management to implement desired changes. In particular, they stalled the planned closure of NHS units in Plymouth for at least a decade. In rejecting incorporation into the Joint Management Group, COHSE had instead been able to act as a catalyst in uniting user's relatives, Starcross staff, Plymouth staff and nurse managers in opposition to the plans of Health Authority and Social Service managers. Although this imposed

major constraints on the options available to the them, it did not remove the underlying policy intention of securing a "cost-neutral" solution. Management instead was forced to identify alternative routes to achieve this.

A New Managerial Initiative

The consequences of this were to be realised in January 1988 when senior managers of Plymouth Health Authority and Social Services announced the establishment of a private company, Havencare. The company was to operate as a private trust, providing small residential homes in the community for the mentally handicapped and mentally ill. Its Managing Director was to be the Health Authority's District General Manager, with the Director of West Devon Social Services becoming its Director of Operations.

For COHSE there was some irony in the fact that the initiative was in part justified on the grounds that the private and voluntary sector was not proving able to cope with service requirements, particularly for clients having more specialised needs. In a letter from the Social Services area director to members of the West Devon Social Services sub-committee the role of the financial regime under which they were operating was explained:

> The need to go to all these lengths to achieve the simple objective of caring for vulnerable people in the community is regrettable, but is necessary, as you know, in order to provide capital for the acquisition of properties and secure the payment of Social Security benefits for the residents' weekly charge
> . . . Our commitment is to ensure that, in the absence of Health and Social Services Authorities being able to finance residential homes in the community directly, a means does exist to meet the real and urgent needs of vulnerable people and their families. It was our assessment that existing voluntary societies working in the residential care field could not provide the style of care required for all the patients now awaiting hospital discharge. For this reason the Havencare initiative was taken. (internal letter, dated 29th July 1988).

Havencare was a management device to gain access to funding sources which would otherwise be unavailable. It was established to resolve the contradiction created by Government funding policies, which made resources available to a private sector which had proved itself unable to provide a comprehensive service. A sub-group of Plymouth Health Authority responsible for mental handicap services received a confidential paper from the management which further explained:

> If Havencare is to have the resources to provide facilities for the mentally handicapped, it must be able to qualify for DHSS benefit and all the other financial advantages which a charity enjoys.
> To achieve this Havencare has to be completely independent from the statutory bodies. The DHSS Commissioners must NOT be able to trace a formal managerial link between Havencare and either the health authority or the social services. (internal Health Authority paper, no date).

The paper went on to emphasise that one consequence of this was that:

> The manager must be independent and be seen to be so. All the policies relating to either the staff or the operation of individual houses must stress this independence. (*ibid*)

After the four to five years in which COHSE had achieved some success in arguing the case for reducing the reliance on the private and voluntary sector Havencare represented a new challenge. Its role was originally confined to the establishment of new homes, which had largely been identified in the 1984 strategic plan as the responsibility of non-statutory organisations. However, by early 1989 some evidence emerged that a wider role was being considered. Confidential minutes of an NHS management meeting held in February 1989 referred to discussion on two of the four units for the mentally handicapped still provided by the NHS. On one of these, Tamar House, it was agreed, "The unit should be transferred to the management of an agency outside the NHS." For the other, Cumberland House, "The unit should be run by the NHS (or) . . . as a registered nursing

home by Havencare." Again this is likely to have reflected the DSS funding mechanisms existing at that time.

COHSE was not able to prevent the development of new services by Havencare but it was able to restrain a shift of existing services into its responsibility. The alliances which it had forged again proved crucial in this process. The basis of these alliances lay in an effective linkage of issues relating to services and jobs; emphasis was given to the former, although concerns over the employment implications of a reduction in NHS provision were never far from the surface. Ultimately however, the influence COHSE was able to achieve was founded upon the twin sources of legitimacy it could lay claim to. The first of these came from implicit endorsement by nurse management, the second from relatives of service users. Without these it seems highly likely that COHSE would have been engaged, not in resisting change, but in bargaining over the terms of its implementation.

The two episodes discussed here suggest that there may be significant opportunities for unions to give more attention to issues of work organisation and not only the terms of employment. Influence in the local negotiated order was important, although in this respect its particular form may be all that makes the health service distinctive from other organisations. Support from users relatives was very important in the case of mental handicap services, but these were relatively unique in having a defined group of users. Where such an opportunity is absent internal pressures arising from an increasing symmetry between public service managers and those of capitalist enterprises may be much harder to withstand. These examples have also illustrated that opportunities for unions may still be constrained by the nature of relationships within management, as in these cases between general and nurse managers.

The nature of occupational identities also emerged as a highly important factor influencing the opportunities for unions to generalise experiences. These were

seen to be very much a product of workplace socialisation, and as such were themselves subject to the influence of the character of nurse management. To this extent the secondary nature of unions is confirmed, but so too is the possibility of alternatives arising. One factor in this may be the role of unions themselves. It became increasingly evident in the research that unions could be extremely hesitant about openly encroaching upon "professional" issues. In adopting this distinction, sometimes more than general managers were prepared to do, they illustrated how influential the bargaining model has become, even where the objectives are extended.

This suggests that those unions which are seen by their members and by others as predominantly bargaining organisations may have difficulties in simultaneously adopting 'professional' roles. It may not be so easy for them to simply supplement existing concerns with those of the 'content and objectives' of work. Nevertheless, in each of the two examples reviewed here, unlike the episodes discussed in the previous chapter, management did not seek to withhold bargaining opportunities until resistance to proposals was withdrawn. An important factor in this was the greater claim to "professional" and user legitimacy which the unions were able to make, even where they distanced themeselves to some extent from these issues. The nature of relations between general and nurse managers was also significant in this. One consequence was that in each of the episodes described here unions did not face the same tensions between maintaining opposition and seeking improvements in terms which had characterised those discussed in the preceding chapter.

Given the importance of relations with different sections of management which all four episodes have illustrated in differing ways, the following chapter considers two examples where the union's need to maintain institutional support from employers came into more direct conflict with wider objectives. These were

concerned with defending the existing basis of NHS provision, arising firstly from proposals to replace an NHS hospital with a private service, and secondly in plans by management to achieve Trust status. The examples are used to assess whether a campaigning strategy may represent an alternative or a supplement to both bargaining and professional strategies.

CHAPTER EIGHT

BEYOND BARGAINING?
CAMPAIGNS AND SOCIAL ALLIANCES

The previous chapter illustrated ways in which union involvement in issues of service delivery could be achieved while noting the difficulties this faced. Three significant factors in this can be emphasised. Firstly, the extent to which service managers accommodated with the objectives of general management; secondly, the character of union organisation in relation to the occupational identities on which it was founded; and thirdly, alliances with service users.

This chapter seeks to explore more fully the possibilities which may be associated with the last of these. It is this, perhaps above all other aspects, which might be held to signify a continued distinctiveness of health service trade unionism, with strategies involving wider public campaigning activities having been advanced by some writers as representing an important model for public service unions (eg Fryer, 1989). The discussion in this chapter seeks to identify factors which may encourage or inhibit such a strategy by looking at two issues which generated both bargaining and campaigning responses. The account highlights the conflict that trade unions can experience between bargaining objectives and engaging in broader social alliances by looking at managerial intentions to involve a private company in the provision of elderly care and proposals for the establishment of a self governing trust.

Defending public provision and seeking recognition in the private sector

Some background is required to explain the context of management's proposals for elderly care at St. Mary's Hospital, Launceston. The town falls within the area managed by Plymouth Health Authority in East Cornwall, situated twenty five miles from Plymouth. With a population of six thousand, Launceston is relatively isolated in a predominantly rural area. There was widespread agreement that St. Mary's, a one hundred and fifty year old former workhouse providing forty five elderly care beds, needed to be replaced. The Health Authority had originally planned to start rebuilding in 1987 but the necessary capital was unavailable from within the NHS. In 1988 discussions took place between senior PHA managers and representatives from a private company, Westminster Health Care, to consider alternatives.

Westminster Health Care already owned Old Trees private nursing home in Launceston, which it proposed to replace with a unit capable of accommodating additional beds to lease to the NHS. Forty beds would be leased to Plymouth Health Authority to replace St. Mary's, with a further twenty beds for leasing to Cornwall Health Authority for elderly patients with psychiatric disorders. In total a new hospital for the elderly with one hundred and seven beds was being proposed.

The company involved is part of a major multinational health organisation. Companies House records show its origins to lie in the formation in 1985 of Isobaran Ltd, registered as a travel agency and having two shareholders each with a £1.00 share. Within five weeks the two shareholders changed the name and Articles of Association at an Extraordinary General Meeting, establishing Westminster Health Care Ltd, registered for, "the provision of private hospitals or nursing homes".

On 19th November a further Extraordinary General Meeting of the two shareholders agreed to increase the share issue to 100,000, redesignating 90% of them to

NME (UK) Ltd and 10% to a Mr. Carter, who became a director and subsequently the managing director (Westminster Health Care, Annual Accounts). NME (UK) Ltd is a subsidiary of the American National Medical Enterprises Inc., described in a standard source-book on international health services as, "among the world's largest health care companies." (Graham and Trotman, 1988). Some of the directors of this company were also installed as directors of Westminster Health Care. In 1988 NME Inc sold NME (UK) to BUPA Ltd. Two years later, BUPA was (unsuccessfully) referred to the Monopolies and Mergers Commission for the scale of its involvement in private health.

Though Westminster Health Care represented a small part of a multi-national organisation its growth has been considerable. In 1986, the first full year of trading, the number of employees averaged 53, rising to 291 in 1987, 641 in 1988, and 850 in 1989. The 1989 accounts show a turnover of £6,019,352 and fixed assets valued at £17,955,826. Mortgages established through the company indicate the buying of properties and land throughout the country, from Yorkshire to Cornwall and Sussex to Clywd (Westminster Health Care, Annual Accounts). This was the stage which the company had reached when discussions took place with Plymouth Health Authority in 1989.

In May of that year the Health Authority considered three possible "options" for the future of elderly care services at St. Mary's. The first was to do nothing, the second to replace St. Mary's with a new NHS provision, and the third was to lease beds from Westminster Health Care. As most people accepted the need to replace St. Mary's, the first option had little backing. The second was effectively ruled out because the Regional Health Authority was refusing to provide the necessary capital. This left Westminster Health Care's proposal, which offered an additional attraction to the Health Authority in anticipated annual savings of £250,000 over existing costs of the service. Even with this being offset in the first year by

redundancy costs, it represented a substantial contribution to the Authority's cost improvement programme target of £924,000. It has already been noted that these were being identified as increasingly difficult to find.

Campaigning for public services

The decision by the Health Authority provided the impetus for a union response which was dominated by campaigning activity. From the outset the health unions, through the JCCN, had expressed unanimous opposition to the proposal, ruling out any accommodation on the plans. Of all of the issues and episodes which were observed, this was the one which generated the greatest public expression of opposition. A local Action Group was established to oppose the proposal which had close links with the staff, being chaired by a Nursing Auxiliary at the hospital. Although a COHSE member, she had not previously been actively involved in the union, neither did she express interest in becoming a union representative. It did not seem to be involvement in industrial relations activities which motivated her so much as defending the local NHS hospital and its service provision.

There was political involvement in the Group, for example its Secretary had previously stood as the local parliamentary Labour candidate, but it received much wider support. This included the collection within a relatively short period of time of a six thousand name petition: a number in excess of the total Labour votes recorded within the constituency in the previous General Election. In addition the group organised a number of local activities and meetings within the area.

By the end of the consultation period on the proposal the Health Authority had received forty six formal responses. Only two of these could be described as representing more or less unqualified support, one of which came from the local Conservative MP. He applauded the proposal suggesting it could, "pave the way"

for similar schemes in the future allowing the Health Authority, "to concentrate on operative treatment and corrective treatment". All other responses were critical of the plan.

Objectors included the Community Health Councils of both Plymouth and Cornwall, Cornwall Health Authority, two consultant physicians, North Cornwall and Caradon District Councils, and Launceston Town Council. A report to a subsequent meeting of Plymouth Health Authority mildly acknowledged: "The Authority accepts that there is opposition to the proposal within the Launceston community".

Buoyed up by extent of local opposition, COHSE which represented the majority of staff at St. Mary's, refused to meet with Westminster Health Care, although apparently such an opportunity had been offered to discuss terms of employment for staff. A statement issued by the JCCN indicated the collective view of staff organisations towards the proposal:

> The decision is essentially one of principle and will unquestionably shape the future of not only St.Mary's but also of other hospitals in the Plymouth District. . .
> The assumption underlying the proposal is that a private nursing home is equivalent to an NHS hospital for the elderly. This is not the case. The difference is not just in terms of who runs the establishment. An NHS hospital, like St. Mary's, is accessible to all according to need. . . . A private nursing home is a commercial undertaking. . .
> The vast majority of the staff are determined to carry on their opposition to the proposal regardless of the Authority's decision . . . Members of the Authority need to take account of the certainty of a long drawn out campaign. (JTUNC, Response on St. Mary's Consultation).

In its response to this, the Health Authority gave a thinly coded warning of the possible consequences of sustained opposition:

> Plymouth Health Authority has negotiated with Westminster Health care for the transfer of all staff irrespective of post, hours of work etc., and in addition is paying severance pay and facilitating early retirement where appropriate. The Authority will

> need to consider the statement that the staff will carry on their opposition to the proposal regardless of the Authority's decision. (PHA, Summary of Responses to St. Mary's Consultation).

The line adopted by the unions was clearly influenced by the strength of public feeling, and the hope that this would be sufficient to cause the Health Authority to change its plans. However, two important obstacles to such an outcome were to emerge. Firstly, the broad coalition of opposition to the plans included a considerable diversity of opinion; and secondly, while opposition to the plan was primarily local the pressures for change came largely from elsewhere.

The local identity of the campaign was an important element in its strength, but it created a specific difficulty for the unions. This arose from the fact that COHSE members at St. Mary's were members of the union's Cornwall Branch despite being employed by Plymouth Health Authority. It was the Plymouth COHSE Branches, which had no members directly involved, which were represented on the joint negotiating structures. One consequence of this was that the leading role on the issue was taken by the COHSE Full Time Officer and there was limited direct contact between the joint union committee and the St. Mary's Hospital staff.

However, because of the unanimity of view within the unions this did not create such a problem as might otherwise have been the case. Instead, what increasingly began to emerge was a divergency of views within the broader coalition of opponents. The unions had explicitly linked their opposition to the proposal to a general hostility to what was seen as a piece-meal privatisation of the NHS. In contrast, the response submitted by Cornwall Community Health Council stated:

> Members . . . ignored the fact that Plymouth Health Authority had gone for a private option; privatisation was not the issue, only the quality and quantity of patient care that was on offer. (Cornwall CHC, Response on St. Mary's Consultation).

In its original summary of the formal submissions received during the public consultation period, the Health Authority management identified the main issues which had been raised:

> Opposition expressed has principally been because of opposition to the private sector, the general ideology of nursing homes, the fear that all NHS facilities will be lost in Launceston and anxieties about the standards of care in the proposal. (PHA, Summary of Responses to St. Mary's Consultation).

From this point on an important element in the strategy of the Health Authority was to loosen the coalition of opposition. The Authority had little regard for objections which it described as "ideological", even though its "pragmatic" response was just as much framed by the current ideology of public policy. More serious attention was given to answering specific concerns. In particular, this related to claims that the higher capital costs included in the NHS proposal were misleading, and criticisms that the lower revenue costs being suggested by Westminster Health Care might signify a lower quality of service.

On the first of these, several objectors who favoured the option of building a replacement NHS facility challenged the estimated capital costs of £2.8 million. This was for a smaller forty-bed unit, compared to the one hundred and seven bed hospital being proposed by Westminster Health Care at an estimated capital cost of £3 million. The Authority's response was that the NHS estimate was based on the Regional capital allocation for such a project, simply adding that the private sector was, "clearly able to build such a facility at a reduced cost."

This issue was taken further by the District General Manager in a letter to Plymouth CHC. This implied that, aside from the problem of capital financing itself, there had been an indication from the Regional Health Authority that it did not regard the service as a priority for calls on NHS funds. The letter stated that the building of a new NHS hospital:

> was rejected by the Service Planning Group and this decision was supported by the Regional General Manager on the grounds of both the service planning issues as well as the lack of capital funds available. (Letter from DGM to Plymouth CHC, 18th May 1989).

Faced with this obstacle attention focused on whether the lower costs of the WHC option might indicate a lower level of staffing and poorer standard of care. This concern had been taken up in an earlier letter to Plymouth Community Health Council from the District General Manager, in which it was stated:

> As a result of the monitoring exercise it was possible for Westminster Health Care and ourselves to compare levels of staffing and the skill mix that was required. This in fact indicated that levels that we currently have at St. Mary's by way of qualified staff are too low and Westminster Health Care agreed to put in the staffing levels that would equate to the findings of the exercise. The position that we have therefore is that the number of staff allowing for a reduction of five beds and the cessation of day hospital activities will equate to about the same as is provided now for the patients that will transfer across to the new facility. However, the skill mix will be improved so as to increase the percentage of qualified as opposed to unqualified nursing staff. (Letter from DGM to Plymouth CHC, 24th April 1989).

It seems that the increase in the proportion of qualified staff may be achieved at the expense of reducing the relative earnings of unqualified staff and altering existing patterns of work. To this extent the private sector was following a similar direction that has already been noted within the NHS. It was also becoming apparent that the organisation of labour by Westminster Health Care was itself proving an attraction to the Health Authority. As the District General Manager noted in his second letter to the Community Health Council:

> The methods of patient care are those which have been established by Westminster Health Care in accordance with their experience both in this country and in America. The system followed is very similar to the nursing process . . . We must not assume that the NHS has a monopoly on the best forms of care as indeed there are several systems which are equally as good. (Letter from DGM to Plymouth CHC, 18th May 1989).

This was accompanied by some further guarantees to the CHC concerning patient care, including an assurance that CHC would continue to have the opportunity to monitor the service. A significant stage in the campaign of opposition had been reached. In the light of these reassurances, the Community Health Council's of both Plymouth and Cornwall withdraw their objections to the proposal. A final and significant factor in this decision was explained in an interview by the then Chair of Plymouth CHC, himself a TUC nominee. He referred to the legislative basis for CHC objections, stated in the relevant regulation in the following terms:

> If the CHC wishes to object to a closure or change of use, it should submit to the Health Authority a constructive and detailed counter-proposal; paying full regard to the factors, *including restraints on resources*, which have led the Health Authority to make the original proposal. (emphasis added).

So long as the Regional Health Authority refused to supply capital for an NHS replacement this could not be offered as a "constructive" counter proposal: in this context the Westminster Health Care scheme became the only viable option. Identifying a practical alternative solution had also created difficulties for the unions. At one stage they had even suggested to the management that an income generation company set up by local NHS managers, Advanced Business Consultants, be used to obtain funding. This was despite the fact that the unions had earlier advised their members to have nothing to do with ABC Ltd., and reflected the real difficulties of arguing for an alternative which external financial constraints seemed to rule out.

The withdrawal of objections by the CHC's considerably altered the situation. As the CHC's represented the only bodies legislatively capable of halting, or at least delaying, the proposal considerable reliance had been placed on their role in

the campaign. Much of the impetus behind the campaign now appeared to disappear. Although the joint staff organisations had promised a long drawn out campaign whatever the Authority's decision, the emerging reality of Westminster Health Care taking over the service began to alter priorities.

Seeking Recognition in the Private Sector

During the period of public campaigning, COHSE had attracted considerable local media attention as a result of which some members of staff at WHC's Old Tree Nursing Home approached the union to join. An early opportunity to identify the attitudes of the company to trade unions was provided when one member at Old Tree faced disciplinary action and sought COHSE representation. She and the union were told by the manager of the home that this would not be permitted. COHSE persisted with attempts to gain the right to represent the member, and eventually the industrial relations officer from the head office of Westminster Health Care became involved. However, he reaffirmed that the company policy was not to recognise unions, though he added that individuals might be accompanied by "a friend".

Shortly after the Health Authority's decision on St. Mary's members of staff at the hospital were invited to interviews with the managing director of Westminster Health Care to discuss their future employment possibilities. The majority of staff indicated that they wished to be accompanied by their trade union full time official. As the staff were still at this time employees of the Health Authority, COHSE made a request to the relevant NHS management for this to be arranged. Given that there had earlier been an informal offer to COHSE by Westminster Health Care to discuss employment, and at Old Tree the company had accepted the presence of a "friend", the response to the union's request from the Health Authority's Community Hospitals Manager seemed uncompromising:

> As Westminster Health Care do not recognise trade unions, you will appreciate I am sure, that your attendance at meetings between Mr. Carter and members of staff on 26th and 27th June could prove to be counter-productive and possibly even exacerbate an even already difficult situation. (Letter from UGM to COHSE Full Time Officer).

The issue was brought to the following JCCN meeting which sought an assurance from the management side that the Health Authority would ensure interviewees could be accompanied by a union representative. A commitment was now given that Westminster Health Care would be approached on the issue, but the management argued that they could not dictate to a private company whether or not they should recognise trade unions. On this it became almost a matter of principle that it was not for the Health Authority to interfere in the policies of a private company. Whatever may have been the form in which the approach was made, it did not achieve the outcome desired by the unions.

It was evident that at important stages in this episode, both COHSE and Westminster Health Care had altered their position on meeting with each other. While COHSE had already met with the company's industrial relations officer at Old Tree, the block on further meetings coincided with the direct involvement of the managing director. It was he who is shown in Companies House records to have been appointed at the time the American-owned NME Inc took the original company over. The American influence may have been a factor in the anti-union stance being taken, although the policy appears to have been maintained following the subsequent buying-up of the company by BUPA.

Two alternative interpretations may be placed on the outcome from this episode. The first would suggest that whatever stance had been taken by the unions, there was little likelihood of securing recognition from WHC and outright opposition to the plan was their only available response. Alternatively it might be thought that had a more accommodative response been adopted to Plymouth Health Author-

ity management, they may have been prepared in the crucial early stages when great efforts were made to overcome opposition, to have pushed for a greater degree of co-operation from the company.

A difficulty for the unions in adopting the latter course would have been that it would have brought them into conflict with many of their own members, apart from other groups and the wider public outside. The example illustrates how public campaigning and the formation of external social alliances against managerial plans can be a high-risk strategy, potentially threatening the level of support which the employer is willing to provide the union.

This may suggest that health service trade unions possess relatively little in the way of distinctiveness when issues of recognition are at stake. For this to be sustained a union may be required to demonstrate a greater degree of accommodation with employer's objectives than might otherwise be expected. This issue was to come to the fore again very soon after the question of St. Mary's had been finally resolved, this time in the context of managerial proposals for the establishment of a hospital trust.

NHS Trusts and Union Recognition

This episode differs from the others in providing an example of union non-involvement in a high-profile publicity campaign organised principally by medical consultants. In many ways it provides an even clearer illustration of the pressures unions may be required to accommodate to if a bargaining relationship is to be maintained. This section develops the theme of whether, within a changing managerial culture, health unions may be required to abandon broader objectives in order to retain institutional support from the employer. Firstly, some background is required on how the proposal came about.

The application for Trust status

The possibility of seeking Trust status emerged out of the Government's 1989 White Paper. Initially in Plymouth there was little evidence of any firm management intent to pursue the option, with the District General Manager writing privately to the South West Regional General Manager to state:

> I am pretty sure we will not be in a position to express any meaningful interest by 8th May because, whilst there is enthusiasm for self-governing amongst managers, there is precious little enthusiasm by anyone else. You may care to advise me whether you would want a management submission and the extent to which we should ignore the views of others. (Private letter from DGM to Regional General Manager, March 1989).

The letter seems to indicate a willingness on the part of managers to accommodate to the views of others. This was confirmed in a further letter from the District General Manager to the Regional General Manager informing her that after discussing the issue with other Chief Officers, "It is our unanimous view that we cannot put forward any proposal at the moment." This was justified by reference to

Government commitments that the, "substantial involvement of those likely to be involved" in a Trust was required. The District General Manager noted:

> The consultant body as a whole is pretty antagonistic to the concept . . . Our preference therefore is not to indicate an interest at the moment but to continue to work with the consultants to try to talk them round. (Letter from DGM to RGM, 2nd May 1989).

While this indicates that the attitude of the consultants was seen by the local managers as the crucial factor, the letter added that among the Health Authority itself, "There is little enthusiasm for the idea amongst the membership . . . I will let you know if I pick up any change of heart". Yet within a few days of this letter there was a surprising turn of events. At the next Health Authority meeting, being held on the closing date for "expressions of interest" in self-government, a proposal was moved from the floor that one be submitted. This was agreed and managers were requested to draw up more detailed proposals. It has been confirmed from a reliable source that pressure was being applied by the Regional Health Authority to submit an application, and it may well have been done in this way to create some initial "distance" between it and the managers.

A prominent voice of opposition to the application within the Health Authority itself had been that of the TUC nominee. In July 1989 the Regional Health Authority announced that he was not to be reappointed for a further term from September. This was the first time that Plymouth Health Authority had not had a TUC nominee, and the decision made it the only one out of eleven Authorities in the South West Region without one. A reliable source within the Regional Health Authority has claimed that the Chairman of Plymouth Health Authority telephoned the Regional office to make it clear that he did not want the TUC nominee to be reappointed. The Regional Health Authority eventually agreed to a new TUC nominee, and the place was taken by a former COHSE Branch Secretary in November 1989.

In the same month the Government published a shortlist of seventy nine proposals to be considered for self-government, and among which was Plymouth. A subsequent confidential management paper on self-government describing the proposed Trust provides a source of information on managerial attitudes and intentions. Firstly, it was to be a large organisation, with four thousand five hundred staff (equating to three thousand seven hundred and fifty whole time equivalents), and operating with an annual budget of £50 million. Much of the document reflects a more commercial orientation, as in the comment that, "The Trust will initiate a number of co-operative ventures with the private sector with a view to developing facilities for cheaper private medicine".

Particular attention was given in the document to the opportunities which Trust status would afford for reappraising existing employment arrangements. One of the greatest benefits of Trust status was described as being the ability to take direct control over pay and labour costs, and thereby, "control locally the largest element of its composition . . . this aspect is the biggest area of challenge and opportunity for its managers".

The unions recognised that Trust status could put at risk some of their existing agreements. From the outset they sought to steer a middle course between not being seen to support the Government's plans while maintaining a dialogue with local management. From the regular joint meeting of the trade unions and management in September 1989 the minutes record:

> The staff side . . . said as a body they remained implacably opposed to self-government but having said that they would want to express an interest in what was being proposed. The staff side wished to invite management to recognise all the unions who were represented on the DJCCN for negotiation and consultation purposes within any new self-governing hospital trust. (JCCN minutes).

At this point the management's response was simply recorded as being: "It was too early at this stage to take up the staff side offer." This response gave rise to

some concern among the unions as rumours were beginning to circulate that fewer staff organisations would be granted recognition within a Trust. Management then agreed to the holding of talks with representatives from the JCCN rather than the whole body. It has been claimed that the talks were agreed to by management on the understanding that the unions would issue no public statements on the proposals for Trust status. No written verification for this exists, although it is noteworthy that of the six issues studied in this research this was the only one on which no public statement was made by the unions.

This approach to collective bargaining by management was very different to that shown by managers of Westminster Health Care. Local health service managers were keen to alter the basis upon which it took place but not to reject it entirely. As a draft document produced by management for the early stage of talks stated, "The Trust will be committed to the process of collective bargaining." However, an important distinction was drawn between union involvement in collective bargaining and their representational role. The document stated that all existing organisations would be recognised for, "consultation and individual representation", but that the Trust:

> will seek to agree the future forum for the local negotiation of pay and terms and conditions of employment in conjunction with the present staff side. (Draft management paper).

While talks surrounding these issues were progressing between unions and management, a very different approach to the question of Trust status was being considered by the medical consultants who were overwhelmingly opposed to the plans. Their own organisation, the Hospital Medical Staff Committee (HMSC), organised a ballot in October which showed seventy three per cent against self-government, twenty two per cent undecided and just five per cent in favour. Of particular significance was the fact that only thirty four per cent were prepared to sup-

port discussion with management on the proposal, with sixty three per cent explicitly rejecting this. The ballot was followed by a meeting of the HMSC at which the Executive was instructed to organise a, "high profile public campaign of opposition".

The HMSC Chairman, who had sought a mediating role, then invited the Health Authority Chairman to attend the next HMSC Executive meeting. After this had taken place the Health Authority Chairman wrote to the HMSC Chairman having, "discussed this problem further", to suggest that, "Instead of requiring the Medical Executive Committee to embark on a high profile public campaign . . . an *ad hoc* group be set up to pursue this aim." This attempt on the part of the Health Authority Chairman to engineer a separation of the campaign from the official representative body was to be unsuccessful. Minutes of the subsequent meeting of the Medical Executive Committee state:

> The formation of an *ad hoc* group separate from the Medical Executive Committee, to embark on a high profile public campaign is not agreed with. The Medical Executive Committee is mandated by the Hospital Medical Staff Committee to initiate and conduct this campaign. (Minutes of Medical Executive Committee).

The meeting then accepted the resignation of the HMSC Chairman and elected a successor. Whereas attempts by managers to dissuade the unions from adopting a public campaign appear to have been successful the rejection by the consultants of such an approach illustrates the important differences between the two. The consultants continued to regard themselves as powerful actors within the organisation. Consultants have not only gained a high level of autonomy in their own work but have frequently exercised a high degree of control over that of others. Trust status may have been seen as a threat to their traditional power, as the impact of general management upon them was still relatively limited. This inde-

pendence was reflected in the pressure which they applied to their representative body.

In contrast, unions had already accommodated with the new managerialism, and entering talks on establishing a continuing basis of this was a natural development. Inversely reflecting the position with the consultants, there was comparatively little pressure from members on this issue. Of all of the episodes considered in this research the Trust proposal appeared to generate the lowest level of trade union member participation.

While partly a consequence of the confidential nature of discussions being held, it is also the case that union representatives were not being subject to pressure from members. Many staff expressed unease about Trust status, but more anger was expressed during this period following an ill-timed announcement by management on the introduction of a car parking fee for staff. When this was immediately taken up by the unions the plan was temporarily shelved.

Such differences also reflected different perceptions of power. As was the case with many members, the majority of union representatives interviewed expressed the view that the decision on Trust status was a *fait accompli*, and faced with this saw their role as preserving a basis for future trade union organisation. Consultants did not tend to regard the outcome with such inevitability, seeing the local general managers as only one set of actors in much wider frame. For example, the consultants were prepared to go over the heads of local managers, making direct contact with officials within the Department of Health in an attempt to undermine their position.

Conflict and Accommodation

For the consultants, a period was being entered characterised by increasing conflict with management. At one point the Health Authority Chairman publicly rebuked the incoming HMSC Chairman for saying that there was a lack of trust between doctors and management, stating he would be "astonished" if this represented the view of the majority of the consultants. This prompted a ballot of consultants on their views about the management; the result showed eighty seven per cent agreed there was a lack of trust, and seventy three per cent felt there had not been good management or effective leadership.

A far less unified approach was becoming apparent from the unions. In negotiating with general managers, the unions were now finding that a new accommodation would require further change on their part. In particular this related to the issue of recognition for bargaining rather than representational purposes. Managerial intentions on this were indicated in a confidential management paper issued only to Health Authority members:

> The Trust will limit the number of organisations it recognises for the purpose of pay bargaining . . . In agreeing these representative organisations, it will be essential to afford recognition to those who are truly representative of the staff. (Internal Health Authority paper).

The statement is reminiscent of that by the Director General of the Engineering Employer's Federation quoted on pages 32-33. Though there was no suggestion of a single-union arrangement, by this time the unions had effectively dropped their claim for recognition of all unions. This was explained by the staff side Secretary of the JCCN in an interview as resulting from a fear that individual unions might otherwise establish their own recognition agreements, undermining the cohesion of the joint body.

The ability of management to gain an acceptance for the number of unions recognised for bargaining to be reduced was founded in large part upon the level of suspicion which was being generated between individual unions. As Willman (1989) notes, much union recruitment effort in the 1980's was being directed towards maintaining existing membership basis through reaching agreements with employers. Informal talks between management and individual unions were undoubtedly taking place, involving on at least one occasion a national trade union official. What was happening was evidently not in the spirit of the TUC's "Code of Practice" on recognition which, it has been pointed out, was not intended solely to apply to "single union agreements":

> The spirit and intention of the Code of Practice was that it would apply to any recognition agreement under which a union which claims an interest is excluded (TUC, 1989).

By the end of 1989 the strategies being followed by the unions and the consultants had diverged completely. Two consequences flowed from this. Firstly, consultants began to make direct attempts to win staff backing for their cause; and secondly, some dissatisfaction was being expressed from within the unions towards their own stance.

Consultants initially sought to gain the support of others within the local health service by distributing a letter to all staff in January 1990, explaining their grounds for opposition and announcing a series of meetings. Within days the District General Manager responded with a counter-letter challenging many of the claims. This was followed by a special issue of the staff magazine which gave a very favourable account of self-government, including assurances that Whitley conditions could be retained by individual staff if they so chose.

Although the consultants appeared to achieve some success in winning staff support, management were equally successful in isolating them from the staff

organisations. Frequent suggestions were made that the opposition from consultants simply represented self-interested defence of their existing contracts. Such claims had resonance for many union representatives who had not in the past experienced support from most consultants. This had been the case in the 1982 pay dispute, and it was a consultant who had been the principal person involved in the grievance over the lack of time-off afforded to the JTUNC Secretary.

Not all union representatives were however satisfied with the low public profile being taken by the joint union committee. Dissatisfaction developed within COHSE, resulting in the calling of a special meeting of the Branch Executive to discuss the issue. This was attended by the local full time officer as well as a national official, both of whom cautioned against union hostility to the application being expressed too overtly. Instead, they emphasised the union's role as being first and foremost to represent members' employment interests to the employer.

Union involvement in broader opposition should, they argued, be through the avenue of the Labour Party. In addition, a suggestion was made that this need not prevent individual members and stewards becoming involved in an *ad hoc* campaign, formally independent of union organisation but enjoying their implied consent. Such an approach is reported as having been adopted in London during the "Hands Off Guys" campaign. While representing a route which had been rejected by the consultants, there were some parallels with the St. Mary's Action Group which gained the involvement of members of staff while being substantially independent of union organisation. Union endorsement of that campaign had been explicit, and at the COHSE Branch Executive some members expressed their desire for a more forthright opposition and the meeting ended rather ambiguously.

Unlike the health unions themselves, the local Trades Union Council become publicly involved in the issue. Comments were made by some health union representatives that while they welcomed this, it was difficult for them to become too

closely identified. An *ad hoc* body, "Plymouth Health Emergency", involving the local TUC, several individual health service union representatives, Labour Party members, and members of the BMA, was established under the auspices of the TUC. For the local TUC, participation in public debate on the issue was not constrained by bargaining objectives.

This also remained the case for the consultants who by February 1990 were being balloted for a third time, this time again on their views about the self-government proposal. Abstentions were not invited and the result showed eighty per cent against and twenty per cent in favour. The cohesion among consultants had been maintained throughout the preceding months. When in April it was announced by the Government that the Plymouth application had been unsuccessful the level of internal opposition was apparently noted in a private letter to district management. In particular, they were not seen to have established a management structure capable of making the proposal work.

A further aspect of this episode worth noting is that while it generated a high degree of public interest and debate it did not create the same level of activity. The campaign which had greatest overt public campaigning activity, around St. Mary's, was instead unsuccessful. An important difference between the two was the linkage between local activity and national decisions which were made by the consultants. This showed how local health managers continued to operate within a "matrix of social power" in which a variety of pressures might still be brought to bear.

This chapter has described potential conflicts for unions in participating in broad campaigns of opposition to managerial policies, while simultaneously seeking accommodation to secure continued bargaining activities. The possibility that recognition might be put at risk where unions engaged in public opposition might suggest it to be a highly constrained strategy, even in the context of health services. Two points however should be noted.

Firstly, considerable differences were evident between the managers of the NHS and Westminster Health Care, reflecting contrasting organisational cultures and traditions. The differences in attitudes towards collective bargaining may have their origins as much in the distinction between dominant British and American industrial relations practices as in that between the commercial sector and public services. The approach adopted by health service managers appeared to have much in common with that of many managements in the private sector in Britain during the 1980's noted in Chapter Two.

Secondly, opportunities for NHS management to seek a reduction in the number of unions recognised for bargaining largely arose because of suspicions and rivalries between individual organisations. Compared to the highly solidaristic stance taken by the consultants as a collective body, the unions were highly fragmented.

Each of these episodes brought to the fore the question of definition of union purpose. They highlighted the fact that the defence of employment and its terms and conditions may not always be synonymous with the defence of public services. Health service trade unions may not organise workforces whose structure is wholly determined by capital, but they nevertheless operate in the context of the wage relationship. This might suggest that maintaining bargaining activities will increasingly come to shape the character of union behaviour. The possibility of alternatives is returned to in the concluding chapter.

SUMMARY AND CONCLUSION

There have been two underlying themes in this research. The first has concerned the nature of organisational change in the health service, including whether recent restructuring can be interpreted as a partial reversal of the processes of 'decommodification' earlier suggested by Offe. The second has related to the secondary nature of trade unions, and the extent to which their structure and character is shaped by the social relations in which they arise. Each of these concerns have analytical and policy implications for the nature of health service trade unionism.

The case study method has been used, not as an attempt to find a typical location for analysing these issues, but rather to provide an opportunity to explore some of the processes which are involved. This chapter is intended to draw together some of the points from earlier discussion, beginning with a consideration of the character of managerial control and the labour process. This is followed by a discussion on developments in union behaviour and organisation, with some concluding reflections on prospects for the future.

Health service management and the labour process

In a review of the Government's 1989 health service White Paper one writer concluded that a major strand in Government policy:

> has been to restructure the NHS along commercial lines with a strengthened management function, facilitating the links with the private sector . . . The White Paper takes this project a large step forward. By instituting an internal market in the NHS, the currency of the market place is being brought into the heart of the NHS. (Bach, 1989).

There is no doubt that change has been dramatic in the NHS, but as the review in Chapter Three showed, much of this has served to confirm tendencies

already evident prior to the Conservative election victory of 1979. In particular, the strengthened managerial function has been put into place as a means of overcoming difficulties faced by the state in securing local adherence to central policy. Increases in central control have arguably been of far more significance than an extension of market forces.

For the purposes of this discussion, the Health Authority selected for the case study offered a considerable advantage. It was one in which the new general managers had appeared to embrace much of the new philosophy, including a willingness to adopt a much more commercial criteria. By their own accounts they were seen at national level as being to the fore in implementing the proposed changes.

There is no doubt that this brought about a major change in the nature of decision taking, but it is questionable as to how far this can be regarded as representing a wholesale process of commercialisation. Probably the clearest example of such a process was in the catering service, with the introduction of the cook chill system in response to competitive tendering. Yet this arose before the introduction of general management, under the combined influence of the compulsory tendering process and strict financial controls.

In many of the other cases which were examined financial resources emerged as a dominant issue. This was certainly the case with the proposals to replace St Mary's hospital, where a private company became involved initially because the Regional Health Authority would not provide capital funding. The difference between this and the situation existing in much of the NHS in the 1950's was that local managers were now given greater freedom to find alternative solutions. Within the constraints in which they operated this necessarily involved them developing contact with the private sector, further reinforcing new elements of the changing managerial culture. Nevertheless, this continued to highlight the relatively limited freedom which local NHS managers enjoyed.

This appeared to provide a large part of the justification for the Trust proposal, which gave great emphasis to the opportunities it allegedly provided for securing capital resources and introducing more flexible employment packages. That this was an unsuccessful bid was in part due to the fact that the local managers had not been able to take consultants with them. In embarking upon a radical proposal, managers found that there was still a need for them to develop alliances with others if they were to carry their policies through.

Much the same applied to the establishment of Havencare, this time as a solution to problems of revenue funding given its eligibility to claim DSS benefits on behalf of residents. An interesting comparison can be drawn here with experiences in Exeter, closely related as a consequence of the Starcross Hospital closure but seemingly involving more harmonious relations between unions and management. This comparison also provides an illustration of the scope for management to utilise existing features of union culture as a means of encouraging a more accommodative response.

Historically, Exeter had a much larger number of psychiatric hospitals than had been the case in Plymouth, a factor which left an important imprint upon the character of union organisation. For example, the Exeter District General Manager published his own account of the hospital closure process in which he describes his initial perceptions when arriving as District Administrator in 1974, two years after a local strike at one of the psychiatric hospitals. He comments, 'It was impossible to discover who was in charge of the hospitals . . . there was a suspicion that the trade unions had perhaps the most powerful voice' (King, 1991, p30).

However, by the time of the closure programme and in contrast to many aspects of comparable changes in Plymouth, the importance of securing support for the service objectives is given considerable emphasis. In this it is pointed out that:

> Exeter's most radical changes were introduced and brought to pass by the now discredited management culture and style

> before the introduction of General Management. Far more important than individual accountability had been the group commitment to a common goal (King, 1991, p38).

Exeter's District General Manager goes on to say, 'Trade unions supported all the changes and helped to make them work' (p57), adding a comment on the role of lay union representatives who he describes as being:

> in contact with grass roots opinion, ensuring they did not lose touch with what was acceptable to their members, and therefore, possible. It was an enormous benefit that all the negotiations were conducted by our own staff and not by paid union officials, simply because this shortened lines of communication (King, 1991, p58).

Interviews with two of the lay union officials involved in these negotiations broadly confirmed this desire to find a mutually acceptable solution. They also indicated that not all members were satisfied with the approach they were taking, but they took the view that closure was inevitable and getting closely involved in the direction of change was essential. Union representatives and the District General Manager further identified the guaranteeing of no compulsory redundancies as being a key factor in securing this supportive union response. On one occasion managers even managed to secure Ministerial sanction for delaying competitive tendering to ensure this commitment was maintained.

In appearing to adopt a more accommodative style, general management in Exeter were able to rapidly move forward with a programme which on the face of it seemed to create a far bigger threat to the unions than was the case in Plymouth, given that it involved large scale closures rather than growth. The major difference between the two areas lay in the relative contribution to be made by the NHS and the private sector in the new services, and this factor was significant in determining the union responses.

However, Exeter health service managers were soon to experience financial difficulties in running the new community based service. The original intention had

been for this to be based in small Health Authority run hostels in which residents would be eligible for DHSS benefits, but this was declared unlawful by the Department in 1986. The solution which was then adopted was to transfer the homes to a charitable body, Home Care Trust, which would lease property from the Health Authority from which it is also granted some additional funds. This bears close formal parallels with the creation of Havencare, although the context and culture in which they emerged was of course very different.

And it is this which illustrates how scope for local variations prevailed even under general management, increasing central control and despite Government funding regimes intended to encourage the private sector. Inevitably this casts considerable doubt upon notions of a more generalised move towards the commodification of health care. However, the issue of ownership could itself be closely linked with those of control. For example, the considerable degree of change experienced by ancillary staff in the competitive tendering processes occurred in the context, as reported by one manager, that management had been given the brief to retain services in-house. This directs attention to the question of whether managers are nevertheless increasingly required to act as if they were capitalists in their control of the labour process (Crompton and Jones, 1984). Of particular interest is whether any such moves would be expected to create a situation in which traditionally heterogeneous groups of staff find themselves subject to more universal systems of control.

The case study demonstrated a very clear change in the extent to which local NHS managers were prepared to alter patterns of work. In this, they were also prepared to go beyond those staff groups subjected to nationally imposed changes such as competitive tendering. Despite this, changes in control over the labour process did not have uniform outcomes for different staff groups. While originating from the same financial pressures these were mediated by social relations other

than those of capitalism alone. Two aspects of importance in this were gender and professional identities, with the two being closely inter-related.

The role of gender-structuring of jobs was clearly evident in the case of the cook chill catering system, where the changes reinforced divisions among the workforce in a way which created further segmentation. Similarly, the introduction of bonus systems based upon budget savings, which introduced a pay cut as well as creating considerable uncertainty about earnings, had its greatest impact upon predominantly female groups of staff. Because of the way in which the bonus was calculated they can additionally be seen as potentially reinforcing an intensification of work among these groups.

In contrast, attempts to control the medical staff proved far less successful, as in the case of the Trust proposal. An intention to challenge some of the traditional control by the medical profession was noted in Chapter Three as being an element in new central policy initiatives, but this proved to be highly constrained. The ability of senior medical staff to use institutional sources of influence illustrated their continuing level of authority. As a postscript to that episode, it is worth noting that in the summer of 1992 a new proposal for a Trust for the general hospitals was submitted, this time with the support and active involvement of the consultants.

Within the internal negotiation of order they were able to renegotiate the basis of the proposed structure and their position within it, appearing to justify the suspicion of union representatives who in 1990 were doubtful about the basis of the consultants' opposition to the original management proposal. The change by the consultants has been justified in terms of the inevitably of Trust status by the later stage and a consequent desire to be involved in it rather than outside of it. In this there are close parallels with the views expressed by union representatives in the Exeter hospitals faced with closure. For both groups a crucial aspect was the amount of organisational influence they could bring to bear, and an important fac-

tor in this was the degree of congruence between occupational identities and institutional representation. In this an important triadic relationship could be observed involving the occupational group, their respective 'professional power holders' (nurse managers and the Medical Executive Committee) and general managers.

An example of this arose in the changes to nurse rotas, with nurse managers being frequently perceived as having adopted the view of general managers despite opposition from the nursing staff themselves. Similarly, many nurses in the mental illness services expressed disquiet about the role of some nurse managers. Within nursing, only in the case of mental handicap services can there be said to have been a consistently high degree of correspondence between the views of staff and their managers, and it was here that general management experienced some of the greatest difficulties in implementing changes.

These examples demonstrate the continuing importance of the notion of professionalism within the NHS, while simultaneously confirming the difficulties which nurses have traditionally faced in utilising it to their advantage. One element in this may be the historically ambiguous role of nurse management. In part this can be traced back to the position of the hospital matron, which Ann Witz has described in terms of the 'moral discourse' embodied in Florence Nightingale's image, involving an expectation of subservience and low pay among nursing staff (Witz, 1992). Despite the formal ending of this institutional role many elements of the culture were arguably retained, a factor having particular significance in a context of the ascendancy of general management. This style stands in stark contrast to the speed with which the consultants in the case study removed those of their representatives who were deemed to have become too closely incorporated with the Health Authority in the original Trust proposals.

Significant in this difference is the way in which concepts of "professional" and "skill" are socially constructed. Although in many ways the extensions to

managerial control over the labour process were analogous to those of a capitalist enterprise, it is also important to recognise specific features deriving from the more distinctive occupational categories of the health service. This meant that organisational influence was often closely tied to notions of legitimacy founded upon those of professional expertise. For example, the success of the consultants was ultimately based, not on their clinical expertise *per se*, so much as their use of this as a source of credibility in securing influence in the "social matrix of power" (Offe, 1984). Nurses were not on the whole able to make such claims effectively, and as was noted in at least two episodes, could be hesitant in combining 'professional' and 'job' issues.

This local experience needs to be located in the context of attempts by nursing to establish greater authority. Past difficulties in achieving this have in recent years encouraged the re-emergence of a credentialist strategy based upon education. However, entry numbers into student nurse training courses have been declining and there have been accompanying indications of a return to the recruitment of less qualified staff. As one review of the social history of nursing concluded:

> If we ask who will be standing beside the patient's bed in hospital providing the direct hands-on routine care in the year 2000, it is difficult to resist the conclusion that it will still be the handywoman class in the new guise of support workers. Indeed, they are also likely to dominate non-hospital, non-family care. . . Professional ambitions must be reconciled with economic realities. No elitist programme of nursing reform has yet been allowed to succeed (Dingwall *et al*, 1988).

In this context it is also relevant to note evidence from nursing in America where nursing staff have achieved new areas of responsibility by arguing the case of their cost-effectiveness. Often this has involved taking over tasks previously performed by doctors. While there is little evidence as yet of similar developments in the NHS, within the newly created Trusts such moves cannot be ruled out. This

however could be seen as representing another form of labour substitution, in a form which meets managerial goals as much as those of nursing itself.

Nevertheless, even with the problems which nursing may be experiencing in the face of encroaching managerial control there were episodes in the case study when opportunities arose for gaining involvement. Leaving aside the degree of collective identity which was shown, which is returned to in the following section, an important distinction must be drawn between control over pay costs and over the labour process itself. To understand the difficulties faced by management in achieving the latter it is useful to return to the notion of "sentimental work" (Strauss, 1983), and the indeterminacy of health care interactions which this implies. While this will always constrain the extent to which nursing work can be subject to managerial regulation there may be the possibility of utilising it more broadly in the context of claims about more responsive services, quality, and the information and choice given to patients.

Despite the very substantial changes described in the case study, much of the evidence also indicated the considerable constraints under which managerial control operated, deriving both from the complex nature of social relations within the health service and from its highly political character. However, the impact of these constraints was not in any way uniform, with much of the case study evidence suggesting they served to reinforce rather than reduce occupational differentiation. A significant factor in this is the lower status accorded to "caring" work, a challenge to which may be more important for many groups of health staff than seeking the traditional attributes of professions.

However, this would require an assault upon conceptions whose origins lie much wider than within the workplace. For this reason alone it represents a difficult strategy at a time when many decisions on work organisation are being shifted to local level. Instead, the evidence from much of the case study material suggested

the likelihood of this encouraging greater attention to bargaining over the terms of change. This is considered in the following section, which examines some of the consequences of organisational and managerial developments upon union behaviour and organisation.

Bargaining and social alliances

It has earlier been noted how the introduction of incentive bonus schemes for ancillary staff in the late 1960's and 1970's provided new opportunities for bargaining over work content and staffing levels. This was seen to be part of a broader, although uneven, process towards the adoption of a more generalised industrial model of trade unionism within the health services in this period. The 1980's in contrast saw the RCN experiencing the greatest membership growth, implying at least a partial turn away from such a model. The early award of a Pay review Body to nurses seemed to offer an endorsement of this rejection of more "unionate" characteristics, although as noted earlier, there was more rhetoric than reality in the Government's claim.

Much of these experiences would nevertheless tend to confirm the secondary nature of trade unions, and in doing so also presenting something of a paradox. The basis of this lies in the differing forms of accommodation available to unions, particularly at the levels of the state and the individual employer. Mechanisms of institutional support may be available at either level, but these can require differing obligations in return. At national level, for nursing staff at least, the style of the RCN appeared capable of achieving certain gains being denied to TUC unions. At the same time, as was evident in the case study, traditional sources of local strength for the RCN were capable of being put at risk by the emergende of the 'new managerialism'.

In the face of this changing local context two principal responses were available to the unions. The first involved giving priority to bargaining over the terms and conditions of change, the second required the mobilisation of internal and external sources of support to resist the content of change. Overall, the case study evidence suggested that the need to maintain institutional support from the employer on the one hand, and the difficulties in developing wider alliances on the other, combined to encourage the adoption of predominantly the former response.

Initially, this was particularly evident for ancillary staff, as existing bargaining arrangements came to be recast as a consequence of competitive tendering. No longer were the unions able to bargain over the details of work study results by reference to national formula. The potential threat of a private contractor changed the basis upon which bargaining occurred, substantially weakening the possibility of gaining union influence. Although unions were being urged from several directions, including their national organisations, to give greater attention to specifications and the content of work in this process, the case study suggested that this was less easily obtained than were opportunities to bargain over conditions of employment for the in-house tender.

Much the same applied to nurses affected by the changes in rotas. It was only in the case of Westminster Health Care, which refused to recognise the unions, that a different situation arose. So far as NHS management were concerned, in the main there was no indication of a desire to bypass unions in bargaining over the terms of change, despite an increasing willingness to assert "management's right to manage" over the content of such change. Partly because of the already differentiated nature of the labour process in health care, this had the effect of further widening disparities. This was particularly so where external pay relativities impinged upon bargaining processes, as occurred in negotiations over payment systems in the cook-chill system. This example illustrated the dilemma facing unions in the new

situation. While an important consequence of change has been an extended scope for local bargaining in certain circumstances this is likely to introduce considerations derived from the external labour market which reinforce existing segmentation. This process is most likely to occur in work which is less distinctive from that conducted elsewhere, and for which market criteria become more important.

Bargaining formed a necessary response to the new challenges, but one which was limited. Differential outcomes aside, a significant problem was the lack of workplace organisation to sustain such a strategy, as was evident in the case of the changes to nurse rotas. The development of workplace organisation was not an insurmountable problem, as was shown by the mental handicap nurses, but this was very closely related to the broader nature of workplace relations in this sector. Here, as among many of the mental illness nurses, there was a close correspondence between job-related and service-related issues. As was noted in the previous section, an important element in this was the role played by nurse managers.

The limitations of an exclusively bargaining model were illustrated perhaps above all in the discussions concerning recognition in the proposed Trust. Increasingly management was able to use offers of institutional support as a means of shaping the negotiating framework. However, this was made possible by the combined influence of weak workplace organisation and inter-union rivalry which in turn reflected a lack of a distinctive union identity among large sections of union memberships. In policy terms this suggests the need either to concentrate upon efforts to develop workplace organisation capable of sustaining effective bargaining activity at local level, or to reassess such an approach with attention instead turning to the building of wider social alliances.

Different views on the possibilities for unions to engage in such alliances have already been noted. Although critics of such a strategy have recognised the

possibility of its relevance to public services (Kelly, 1988), advocates have also noted the limited extent to which it has been adopted (Fryer, 1989). One question which the case study sought to address was whether and how far this might be considered as a viable strategy.

This certainly appeared to be the case in the mental handicap services where an alliance with users' relatives was of considerable importance, although this service was relatively unique in having a defined population of users. Where this was not so, as in the two examples where attempts were made to generate wider campaigning activities, outcomes could be considerably different. Nor did these outcomes necessarily correspond with the level of public activity. Resistance to proposals to replace St Mary's Hospital won a large amount of local support but was ultimately unsuccessful, while the successful opposition by consultants to the Trust proposal had not generated as much wider public involvement.

An important factor in explaining these outcomes is the level at which relevant decisions were being taken. In the case of St.Mary's Hospital the final decision was constrained by those taken outside of the locality, for without Regional approval for capital expenditure the local Health Authority could not proceed with its own development. The very local nature of the campaign contrasted with that orchestrated by the consultants who went to considerable lengths to influence decision-takers at a higher level. In a structure as politically complex as the NHS there can be a need to achieve an influence at more than one level, reflecting Offe's notion of 'cumulative arenas of conflict' (Offe, 1984). In policy terms this has considerable organisational implications for unions where local organisation may be inadequate to effectively intervene in the 'matrix of social power.'

But arguably of greater significance than such organisational issues is the basis of legitimacy upon which any such campaigns are to be founded. Again this

arises from the nature of the relationship between jobs and service issues. To a large extent the ability of the consultants to generate public support for their stance reflected the traditional hegemony of medicine in Western health care ideology. In the eyes of many this gave them far greater legitimacy than that enjoyed by general managers.

In contrast, other staff groups found it more difficult to mount campaigns where concerns over services could be represented as a subterfuge attempt to protect jobs. As has been noted, on several occasions this produced a hesitancy on the part of unions in engaging too directly in service issues. In addition to the social construction of professional legitimacy, this also reflected the legacy of the distinction between industrial and political objectives and methods, with the former having historically been constructed as the primary purpose and activity of trade unions.

However, several of the episodes described in the case study served to question the continued relevance of such a 'role-model' for public service trade unions. One of the difficulties facing a transposition of industrial methods has earlier been noted in relation to strike activity. Yet there seems no reason why the notion of "willingness to act" (Offe and Wiesenthal, 1980) need be restricted to the withdrawal of labour. After all, this sanction itself came to replace earlier ones of riot and sabotage. It may even be the case, contrary to Kelly's argument, that social alliances are no longer to be associated with the public sector alone.

From German metalworkers to British coalminers there have been examples of trade union based campaigns designed to win broader popular support, suggesting the need for a broader reassessment of the relationship between consumption and production. The tendency to sharply distinguish between the two has had a long history, and is evident in much academic analysis as well as Labour movement activities themselves. Because trade unions arise in the context of the wage

relationship they inevitably concentrate upon the sphere of production, but workers are also consumers within a cycle of exchange.

The failure to overcome this distinction, evident within the case study, is most immediately explained by the fact that bargaining and campaigning activities were not always easily sustained alongside each other. Largely this was a consequence of the potential threat that campaigning might present to more formalised institutional arrangements between management and unions. However, a further important factor to consider is the relationship between campaigning and the broader notion of a 'willingness to act' on the part of members.

The potential for campaigns to generate membership activity was an important strength of the St.Mary's campaign, with the involvement of local hospital staff, not themselves union representatives but motivated by a concern over the threat to the hospital as well as to their jobs. In this instance in fact such staff seemed less inclined to make the distinctions between 'jobs' and 'service' issues more frequently made by union representatives.

This points to an important aspect concerning the relationship between definitions of union purpose, sources of institutional support and union participation. Powerful pressures towards the 'incorporation' of union representatives was not simply the product of negotiating processes encouraging a greater degree of accommodation towards objectives. More than this, the character that such objectives took was coloured by these relationships from the outset. In other words, objectives of influencing the conditions of employment required formal bargaining arrangements which in turn encouraged the articulation of such objectives. Ends and means became mutually reinforcing. Potential consequences this might have for union democracy are illustrated by the discussions held concerning bargaining arrangements in the proposed Trust, conducted with very little in the way of member involvement.

There are parallels here with Offe and Wiesenthal's notions of 'monological' and 'dialogical' patterns of membership communication, the latter being more restricted and sustained by the existence of alternative systems of organisational support from employers or the state. In pointing to the links between internal union democracy and sources of external support the case study evidence also contradicted the idea of an 'iron law' of oligarchy. Although some episodes occurred which might be described as reflecting the 'bureaucratisation of the rank and file', these were also highly circumscribed.

Nevertheless, episodes of greater membership involvement were relatively few, and this was not simply attributable to a lack of encouragement by the unions. For much of the time a relatively small number of activists sustained union organisation and participated in most decision-making. While this did not generally pose an inherent obstacle to bargaining activity, it was far more of a problem in relation to more campaigning activities. For these a more 'dialogical' pattern of membership communication was required if members were to become involved, as indeed occurred in the mental handicap services. Alternatively, as at St. Mary's, campaigning bodies could develop semi-independently of union organisation. This difference was at least partly a product of differing occupational and organisational contexts.

The need to locate processes of union decision-making within their work and occupational context raises a further issue, essentially one which is emphasised more generally by contingency theories of organisations. In seeking to explain internal organisational variance as a function of external environmental factors an obvious problem with this approach is a tendency towards determinism. A first step in avoiding this pitfall is not to make too sharp a distinction between internal union processes and the external environment, given that the 'secondary nature' of unions reflects the close correspondence between the two. Then it is necessary to consider

the generally low level of membership participation in union affairs, for it was this that stood in marked contrast to the consultants who were able to impose a considerable counterweight to the pressures towards incorporation being experienced by their own representatives.

As was also shown in the nurse rota proposals, the pressure of membership and management influences upon unions could be a dynamic process, at times undermining opportunities to create a more stable framework. This suggests that policies designed to encourage greater membership involvement could have unintended consequences in creating new sources of tension with efforts intended to secure institutional support. At the same time, greater membership involvement appears essential if more effective workplace organisation is to be established.

This paradox suggests that the relationship between union democracy and employer accommodation comes to be reassessed at significant periods of organisational change, as has been experienced within the NHS. How this is resolved can be significantly influenced by the definition of union purpose by union members, in turn a reflection of the character of their own occupational identity and experiences. Some implications of this for the future prospects of health service trade unionism are considered in the final section.

The Future for Worker Organisations in Health Care

A significant feature of the case study was that in none of the examples considered was there any substantial evidence of a desire among staff to reject collective organisation. On occassion the opposite was true, as in the approach by staff employed by Westminster Health care to join a union. Equally, the only example of management refusal to recognise a union came from that same company. The continued evidence of attachment to trade union organisation would seem to have con-

siderable significance in the context of some claims concerning a perceived shift away from collective identities. However, it would equally be wrong to conclude that continued allegiances were founded upon deep and abiding senses of loyalty. References have earlier been made to several examples suggesting this was not always the case, including the movement of members between organisations, and criticisms and frictions within as well as between unions.

Instead, much of the material from the case study would lend some support to points made by Scott (1990) on the need to look at collective action in both macro and micro terms. For the latter, particularly in response to the influence of writers such as Mancur Olson, it is important to, 'locate processes of preference formation within collective action and not merely as an exogenous variable' (Scott, 1990, p122). At the same time, suggests Scott, it is important to look at sources of instability within collective action, an aspect often ignored when attention is principally devoted to its persistence.

On the first of these points, the case study indicated a close association in most of the episodes between objectives and what was judged by participants to be possible. A word used in relation to proposed changes on several occasions was that of 'inevitable', even though this did not always turn out to be the case. In such situations individual preferences were very closely associated with levels of collective confidence, in turn adding to potential uncertainty.

For Olson (1965) a likely response from unions would be to emphasise individual, private and selective benefits, which to some extent has been reflected in decisions taken by national union organisations in recent years. This has not been a major focus for this research, partly because such a reversion to a 'friendly society' role is not judged to be a viable alternative and in any event has even more limited relevance for local organisation. This is not to deny that an extension to individual services may not continue, but that this will have to form part of activities more

directly concerned with work itself. Of particular relevance are those described earlier and used as a framework for the case study, namely market unionism, and representational, professional and campaigning strategies.

Examples of each of these were found within the case study episodes, although this should not be taken to imply that they could always be complementary to each other. Instead, as observed earlier, there is considerable scope for tensions between each of these strategies, at the heart of which lies the question of control over the content and nature of work. The case study material showed these four strategies to be essentially representing two alternative methods of pursuing at least two different sets of objectives. Ways in which each of these came to be adopted suggests that the typology of union strategies described earlier (Table 2.2, p46) can to an extent be recast. Where they were then located in terms of sectoral contexts they can now be seen to be equally well locatable in terms of aims and purpose.

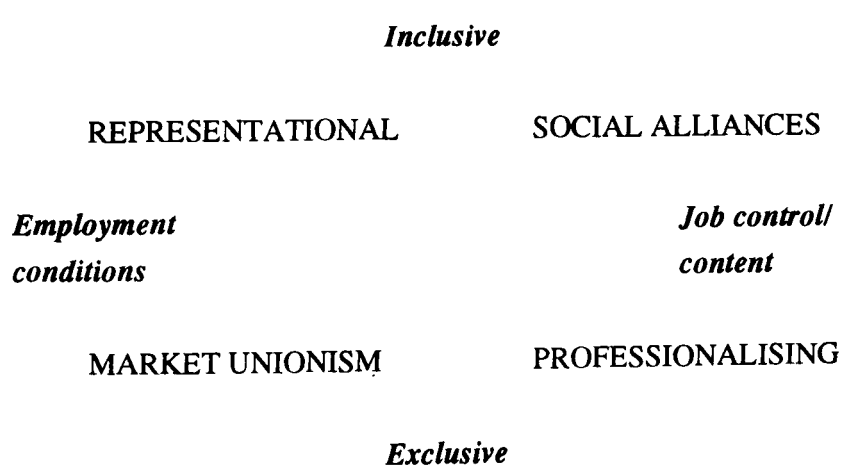
Market unionism and representational activities were both intended to secure improvements in the terms and conditions of employment. In accommodating to change, and negotiating over the terms of its introduction, the unions performed a role which otherwise would have been left undone, with many staff being otherwise worse off. Moreover, health service managers were prepared to provide institutional support for unions in performing this function, suggesting that in organisational terms trade unionism has a relatively secure future in the health service even though much of the institutional basis upon which it rests has altered. The selection of either market-bargaining (as in the cook-chill negotiations) or more representational activities (as with the new nurse rotas to a large degree) was highly influenced by both the institutional response of management and the nature of workplace organisation.

In contrast to both of these approaches, the other two strategies are based upon greater linkages between the conditions of employment and the content and

context of work. While the professionalising strategy required a sufficient legitimacy to intervene in questions concerning work content and the form of its delivery, campaigning activities demanded public support over issues often relating to the organisational context of work. Winning this could be made easier where a claim for accepted professional expertise was also made, although this was not essential.

While there may be scope for some combination of activities by unions there remains important underlying points of difference between them. Alongside that of the relative emphasis upon the content or conditions of employment are the ways in which boundaries are drawn around the groups to which they apply. The social construction of skill and the gender-structuring of jobs can cause both professional strategies and market-bargaining to become divisive and even elitist. On the other hand, representational activities together with broader campaigns and social alliances can be seen as attempts to develop more inclusive strategies. It is therefore possible to locate the four strategies along two dimensions as in Figure 9.1.

Figure 9.1 Matrix showing union strategies by objectives (horizontal) and boundaries (vertical)



This is of course a simplification, but as such nevertheless poses two fundamental questions for trade union strategies: what are the objectives being pursued and for whom? On the first of these, if the slogan, 'Defend Jobs and Services' is to be more than an empty one a reassessment of union purpose is essential. Opportunities undoubtedly exist to recast debates on efficiency, quality and effectiveness, and to address issues concerning the control and democratisation of public services which affect both users and workers within them. Equally, finding ways of altering the relationship between paid health work and the increasing burden being placed upon unpaid domestic labour in the home need to be explored.

Developments along these lines would be required to overcome some of the long-standing distinctions between a focus on the conditions and content of employment, and of that between the industrial and the political and the professional and the manual. However, such distinctions have been deep-rooted and persistent, and are very evident in legal definitions of a legitimate 'trade dispute'. Workers resisting privatisation, for example, need to demonstrate their concern with its impact upon employment conditions and not its effect upon services.

Furthermore, for the majority of union representatives the most pressing questions are ones determined by immediate bargaining and representational responsibilities. Where these are accepted by management as being the legitimate concern of trade unions the granting of institutional mechanisms of support can reinforce an emphasis upon such concerns. This need not mean that no involvement in wider issues will be supported, but that this may well take the form of *ad hoc* bodies from which the unions keep a degree of formal organisational distance.

There are thus a range of pressures upon unions to restrict their field of engagement to issues related to conditions of employment. Much the same applies to attempts to broaden boundaries of inclusion. Certainly so far as the law is con-

cerned, while it will accept the legitimacy of a trade dispute designed to pursue the most narrowly conceived sectional self-interest, it will find against any who would seek to further the interests of others. And even without such legal interpretations, the occupational identities among many work groups themselves is a powerful force which not simply restricts the generalising of experiences but causes many of these to be experienced differently from the outset.

And yet, as with the potential opportunities for linking issues concerning the conditions and the content of employment, so too there could be ways of avoiding some of the problems of sectionalism and professional elitism. One approach would require a shift away from an emphasis upon technical competence and expertise, which frequently lie at the heart of socially constructed definitions of skill, and towards a recognition of the importance of Strauss's notion of 'sentimental work'. As hinted at earlier however, this would involve a much wider assault upon definitions of skill, particularly in relation to caring rather than curing, which do not emerge solely from within the workplace.

All of this suggests that notwithstanding the possibilities of an alternative strategy emerging, existing pressures and constraints present enormous obstacles to its widespread adoption. To embark upon a wider strategy founded upon the establishment of broader social alliances would also involve a substantial reassessment of union character. It would mean seeking to alter existing social relations rather than simply expressing them.

For these reasons and others the continuation of an emphasis upon bargaining-based activity seems most likely. In the context of the NHS, where there has now been several decades of high levels of union membership, this may take the form of market unionism, although in many cases representational activities may predominate. But in either case it must also be recognised that the basis of such organisation and behaviour is always unstable, as was shown in the case study

through the experiences with Westminster Health Care. Perhaps untypical for today, it may nevertheless represent a significant portent for the future. In the absence of effective workplace organisation, continued managerial support for existing bargaining mechanisms cannot be assumed. This much was evident in the NHS managers plans for collective bargaining and representation in the proposed Trust.

This being the case, unions organising within the health service would be unwise to devote exclusive attention to bargaining activities. Early indications from Unison suggest an intention to engage in wider issues, and identifying organisational mechanisms for developing activities on different fronts may represent an necessary task. The important question however is not only that of the organisational survival of trade unions, vital though that in itself is. It is also about re-establishing the legitimacy of unions being involved in a range of issues of social and economic concern. In this sense the future of collective worker organisation in the health service is bound up with that of wider issues of public policy.

It is possible to conceive of two future scenarios for the organisation of health and other public services. One revolves around the endless development of efficiency targets, quantifiable performance indicators, and other such 'neo-Taylorist' techniques. In focusing upon how much as been done, as with hospital discharge numbers, far less attention may be given to how well it has been done, as with the proportions of readmissions. Alternatively, therefore, the future could be one in which concerns about quality and service are continually to the fore, with wider workforce and public involvement in setting priorities and objectives being considered essential.

At the moment the direction of movement generally seems to be towards the former, and challenging this requires a reassertion of the benefits of democracy and participation against narrowly conceived managerial prerogatives. Some decisions

taken in the context of health care priorities are not in any event questions of formal rationality as of substantive rationality, and to follow Weber's approach, democracy is a vital and important ingredient in tackling such matters. Yet increasingly change is moving in the opposite direction. For this reason, even though the interests of workers and users may not always coincide, extensions in the involvement of each is neither contradictory or undesirable. Instead, this would represent a vital counterweight to either managerial or professional dominance on the one hand, and an important encouragement to wider participation in society on the other.

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