A panic measure with hidden hazards

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The first important strike in the NHS was in 1968 when medical laboratory technicians stopped work for one day over a pay dispute. Two years later electricians took industrial action and since then almost all the major groups of Health Service employees—including doctors and nurses—have taken part in some form of protest action. So from perhaps the most quiescent and undeveloped industrial relations system among State enterprises the NHS has become one of the most active and strike prone in Britain. Though the widespread national disputes over pay that occurred last winter may be more memorable, the most typical strike is localised, unofficial, and usually focused on issues quite unconnected with pay.

Because local disputes of this kind were becoming commonplace the former Secretary of State for Social Services, Mr David Ennals, took the initiative of calling a "round table" conference of those who were principally concerned—representatives of the unions (including the BMA) and the management.¹ The conference discussed whether agreement could be reached on a new NHS disputes procedure which would cut to a minimum the number of disputes that led to unnecessary industrial action. Afterwards, in October 1978, the DHSS published details of a proposed procedure.² This was designed to cover local disputes and problems other than those concerned with pay. The DHSS statement gave as examples of the issues to be covered: duty rotas, staffing levels on the wards, arrangements for parking bicycles, or even personality clashes between staff. In short, it was intended to cover a wide range of residual matters outside the Whitley Council system, most of which had been traditionally decided by management without any kind of formal consultation or negotiations with representatives of the staff affected.

Since the "round table" initiative the proposed local disputes procedure has been under negotiation by unions and management. While some differences of opinion remain, the management and the staff sides agree on the basic guidelines. Some of these are unexceptionable. It is proposed, for example, that disputes should be resolved at the lowest possible operational level with the minimum of delay; and that there should be an agreed four-stage procedure for referring the dispute upwards if the local manager cannot resolve it, firstly, to the next layer of management, then to the chief officer of the employing authority, and finally to the employing authority. Such disputes procedure is a common feature of industrial relations machinery in other organisations and industries. The proposed procedure also contains what is commonly known as a status quo provision. This requires that the arrangements extant before the dispute should be reintroduced until the dispute has been resolved—namely, the unions should withdraw sanctions and the management should unscramble any change in working practices it had introduced. The intention is to provide a conciliatory climate in which the dispute may be resolved.

Use of arbitration

But the procedure does not end there: the most interesting aspect is an arrangement whereby any dispute not resolved after reaching the fourth stage—that is, after reference to the employing authority—may be referred at the behest of either

party to a locally convened appeals panel and, if still unresolved, on from there to arbitration. This means that NHS management is prepared to concede (whether knowingly or not) that the entire range of its strategic or tactical managerial decisions could be referred to arbitration at the behest of the recognised union concerned in the dispute. But some matters are quite inappropriate for arbitration. For example, it is impossible to run the financial policy of the Health Service on the basis of a series of ad hoc arbitration awards. Such strategic management decisions in the Health Service have to be taken by members of statutory health authorities. This does not mean, of course, that the NHS unions should not have some voice in these matters but as in other industries and organisations their voice would usually be heard through consultative machinery or representation. It is particularly astonishing that unilateral access to arbitration should be conceded for non-negotiable issues when no such arrangement yet exists for some of the most negotiable issues.

This concession by NHS management is a most unusual—indeed, probably unique—step to take. I cannot imagine management in the electricity industry, for example, conceding a disputes procedure that would allow its power station building programme to be referred to an independent arbitration tribunal. How could a tribunal seriously resolve such a matter, except perhaps to recommend building only half a power station? A decision of this nature is strategic and must be determined at board level, though there would no doubt be prior consultation with appropriate unions. I use this comparison with the electricity industry because industrial action there can also put human life at risk and the same case could be made for arbitration to be easily accessible at local level for the electricity industry as for the Health Service.

If this proposed disputes procedure were implemented it is very probable that the financial cuts now being implemented in the NHS, which are causing widespread local anguish, would be referred by the unions to arbitration. According to the criterion laid down in the procedure, this would be a proper subject for reference, as the finance policy of a health authority lies outside the remit of the Whitley Council system and is not negotiable. Those trade unions in the vanguard of the campaign against cuts must surely welcome the prospect of a procedure that would enable them to refer any local management decisions to arbitration—in particular, the detailed policies for cutting patients' services. Would it be unrealistic to suggest that the cuts might well be halved if the common arbitration practice of splitting the difference between the parties were adopted?

Where is management's backbone?

How is it possible for NHS management—by which I mean both members of statutory authorities and their administrators—so to lose its backbone as to succumb to the unique proposal of transferring its strategic policy-making function to an independent arbitration panel? I will not comment on whether management should increase or decrease the range of subjects that are negotiable with union representatives. There may be justification for moving the frontier of management control to enable employees' representatives to exert greater influence over management decisions. Where and how to establish the proper balance between management's function in determining strategic policy and the unions' wish to influence such decisions are questions that can be settled only in the light of the particular circumstances of an industry or organisation. The importance of this likely turn of events is not that these "managerial

functions" may be sacrificed by becoming arbitrable but that NHS manager seems unaware of having offered them up for sacrifice in the first place.

Not for one moment would I impute improper motives to the Service's managers and it is fruitless to suggest that this potential disaster may happen because health authority members and their administrators are forgetful or neglectful of their duties or responsibilities. We need, instead, to ask how the structure of NHS management led the participants to be so unaware or unconcerned about their proper functions that these may be so readily tossed over to an arbitrator. Several factors have combined to weaken the fabric of managerial responsibility in the NHS. Firstly, the normal line management of many private and public sector organisations is hard to identify in the NHS. The influence of doctors, who inevitably take many of the "spending decisions" every day in the surgery or by the patient's bed, makes the establishment of normal line management difficult. This has been recognised and in some ways reinforced since NHS reorganisation by the consensus management concept embodied in district management teams. Secondly, the lack of effective trade union organisation in the past has produced a generation of administrators unaccustomed to defending their managerial functions against incursions and encroachment by union representatives. Thirdly, the often arbitrary interference by the DHSS in local management has undermined administrators' authority and confidence. Finally, the NHS lacks any readily identifiable criteria for management to apply to allocation of resources. Outside the NHS various types of constraints—whether these arise from the logic of the marketplace, political control, or consumer control—establish a firm framework of criteria which should be applied to resource allocation. The Health Service, though formally subject to political control and consumer influence, is in practice faced with a confusing variety of criteria, which weakens still further the managerial function.

Irrespective of what may have contributed to this vagueness about management functions within the NHS, a further aspect of the proposed disputes procedure may have unintended consequences. In its present draft form it can be inferred that sanctions would normally have to be applied or threatened by the staff concerned before an issue could be referred to it. Were this not so it would be difficult to define what constituted a local dispute for the purposes of invoking the procedure. This is hardly surprising since the intention behind the original arbitration discussions was to avoid unnecessary strikes. But if the procedure enables important matters not currently open to negotiation to be referred to arbitration—for example, junior doctors' staffing levels in a particular hospital—then unions have an incentive to threaten sanctions (but not necessarily strike action) so as to invoke the procedure.

The potential short-term benefits to be gained by any union from this procedure are substantial. These are not limited to those organisations representing ancillary staff: there are many issues affecting doctors, particularly those in the training grades, which are not currently negotiable and where favourable arbitration awards could improve the conditions under which doctors are required to work. On the other hand, the ability and determination of management to manage could be eroded and a greatly weakened NHS management would be to the

detriment of the Health Service and its staff—not to mention the patients. A management that has sacrificed its capacity to determine the allocation of resources, either directly to a series of arbitration awards or by merely pre-empting such awards by adjusting its own actions and policies accordingly, is unlikely to prove effective in obtaining the necessary resources for the Health Service. In other words, weak management is vulnerable on two fronts, not only from domination by its own unions but also from domination by others who wish to limit the resources available to the Health Service.

Some might suggest that this disputes procedure has no real importance anyway because no one is obliged to accept the arbitration award. My reply is that the very idea of entering arbitration without a prior commitment to accepting its findings as binding on both parties is utterly pointless and is the quickest way of destroying the procedure.

Panic measure

The procedure was conceived at a time of panic and despair. The rapid worsening of disputes and the apparent failure of local management to resolve or contain them led to a widespread belief that something should be done—and sooner rather than later. The outcome is a proposal which in effect gives de jure recognition to the de facto standing of NHS management. Although most doctors would say that the functions of management have already been effectively conceded in the NHS, this is an unexpected and unwelcome consequence. Sadly, management's handling of the numerous local disputes, together with the Government's willingness to support and encourage retreat from proposals for cutting NHS expenditure in the face of concerted opposition from unions and other interested parties, means that both the Government and NHS management have in practice completed this transfer of management functions.

Some Health Service managers are aware of the importance of their responsibilities as managers and have tried to stop them slipping from their grasp. But to their chagrin they have found that their attempts to withstand the demands and pressures of union representatives are often not supported either by members of a health authority or by the DHSS. Frequently, a firm and consistent local stand finds no support higher up, leaving the individual manager exposed and isolated—a poor advertisement for the 1974 reorganisation's objective of delegation downwards and accountability upwards. National politicians and health authority members too often prefer the popular and prompt expedient action. While such a surrender reduces trade union pressure in the short term, the long-term price is the erosion of the functions and responsibilities of NHS management. Unfortunately for the NHS, those who opt for short-term expediency know that they will not suffer its long-term consequences.

¹ *Br Med J* 1978;ii:1237.

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any government which will meet the profession's wish to abolish certification for short periods. However, because they make a radical change to income provision during sickness, they will take time to bring into operation and your members will I am sure understand that the necessary legislation cannot be passed quickly. Now that there is a real prospect of achieving their objective, however, I hope that doctors will feel able to call off their proposed action in the knowledge that this Government

has recognised their problem and is prepared to act as quickly as practicalities allow.

I should also like to help you to curb the growing abuse to which you referred of national insurance certificates being wrongly asked for and used for employers' purposes only. This is clearly contrary to the rules and procedures we agreed some years ago with the BMA, CBI and TUC. It would seem from what you told me that some employers are not following the procedures correctly. I have asked my officials to look into this and to initiate discussions with

you, the CBI and the TUC, to see what might be done to stop the improper use of national insurance certificates.

As to the sick-pay scheme itself I know you have reservations about the effects it could have on your members both as providers of medical certificates and as employers. I can assure you there will be full and proper consultation with the BMA on both these aspects. I would ask you, however, to wait until the Green Paper is issued before discussion of these problems begins.