NHS pay and the 10% ceiling

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Each year the NHS negotiating season begins with the ancillary staff, the craftsmen, and the ambulancemen in December and January. It continues with the main professional salary awards, including those of the doctors, in April. This year there has been a masterly inactivity, described by one leading trade union official as "the race to be last." No one wants to be the first to settle within the official limit and with a sigh of relief many trade union officials are sitting back to await the outcome of the firemen's dispute. Clearly, if the firemen lose it is going to be easier for trade union officials to begin talking realistically "around the 10% mark."

Not only has the 10% earnings' ceiling slowed down the pace of negotiations, but it has also created a problem that could bedevil NHS pay negotiations in the early months of 1978. The problem concerns the cost of consolidation. For the last two years pay settlements have been in the form of cash sums paid in addition to the basic wage or salary but not incorporated into it. Many Health Service staff enjoy what are called premium rates for certain types of work. Overtime working, rest day working, weekend work, etc, are all paid at an enhanced rate—for example, time-and-a-half or double-time. These rates are calculated from the basic wage or salary. Because the last two annual pay awards have not been consolidated into the basic rate they have not been taken into account in the calculation of premium pay. This year, for the third year running, the Government's ceiling is expressed in terms of earnings rather than rates. This means that negotiators have a choice; they can either claim another non-consolidated 10% cash payment or ask for the earlier settlements to be consolidated, in which case earnings will rise automatically because of higher overtime and bonus rates, etc, and the size of the cash

award will have to be smaller than 10% to take account of this rise.

The negotiators' first problem concerns the different effects of the choice between total consolidation and no consolidation at all. No consolidation at all will benefit the lower paid because all staff will receive the same percentage increase. Full consolidation would benefit those on higher earnings because staff with the most extensive bonus schemes and working the greatest amount of overtime will obtain the greatest benefit from paying for consolidation. Those without premium pay earnings could only expect to obtain some percentage increase below 10%.

Costs of consolidation

Consolidation raises two other problems for the NHS. If we suppose that the cost of full consolidation for the ancillary staff is 3%, this would make possible a national settlement of 7% plus full consolidation. The average cost would be 10% but the actual cost would vary enormously between area health authorities. For those that rely heavily on overtime, etc, the cost would be much higher and in certain cases certainly in excess of 20%. Other AHAs might face a bill of only 8% or 9%. How will this variable cost be funded? If the DHSS relies on the standard lump sum allowance, currently 12% for 1977-8, some authorities will have to make savings in other areas. If the DHSS is prepared to consider variable funding the calculations could be difficult.

There are strong grounds for believing that the DHSS does not favour variable funding. This is connected partly with the second problem of consolidation. If the last two years' settlements are to be fully consolidated the cost of that consolidation will be greater in

percentage terms for the ancillary staff, the craftsmen, and the ambulancemen than it will be for other professional staff. The effect of this would be to give the salaried staff—for example, nurses and midwives—a higher percentage payment during 1977-8 than the ancillary staff because they would receive less from consolidation. Such a variation would be embarrassing to the DHSS (because higher paid staff would appear to be receiving higher settlements) and the DHSS is likely to prefer a solution that minimises the size of that gap. The true cost of consolidation is difficult to establish in practice and protracted negotiations on the Ancillary Staffs Council might produce a settlement that rather underestimates that true cost. The eventual real cost would only be known centrally if the DHSS undertook variable funding. If nurses' negotiators knew the real cost they would insist on an equivalent percentage for their own members even if it were more than 10%. So there may be little encouragement for those area health authorities that wish to argue for variable funding.

NHS as single unit?

In the next few months several variations are possible. The DHSS might opt for partial consolidation: such a scheme has already been offered to local government manual workers and means payment of the full costs of consolidation over the next two or three years. If this option were adopted the problem of calculating the effect of partial consolidation would remain, as would the problem of variable national settlements between the different Whitley councils. A further option, favoured by the lower paid, would be to treat the NHS as a single unit and average out the cost of consolidation across the settlements undertaken within each council. This would be resisted on the Nurses' and Midwives' Council, on the Administrative and Clerical Staffs' Council, and by the medical and dental professions.

A final option would be for the DHSS to do nothing at all about the problem of consolidation. This would mean delaying the problem this year by paying everyone a non-consolidated cash increase of 10%. This may resolve the short-term problem but only at the cost of creating even greater problems and anomalies next year. Premium payments would become less realistic and certainly less attractive to the staff who work for them. This in turn could lead to considerable pressure for consolidation in 1978-9. By then the problem would be greater, the anomaly would be more extreme, and it would be much more difficult to resolve without conflict.

Before the management side of the Whitley Council was reformed as a result of Lord McCarthy's recommendations¹ the easier short-term option would have been the most likely. Our new, vigorous, independent-minded management sides might have the strength to face up to consolidation before the problem gets out of hand. Either way this year's wage and salary negotiations are likely to be more interesting and important than for some years.

Reference

¹ DHSS, *Making Whitley Work*, London, DHSS, 1976.

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Rural dispensing in England and Wales—continued

(8) The NJC should have wide power to enable any decision on a proposal or appeal to be conditional on measures to ensure that the effects of the change would be gradual.

(9) The DHSS should consider making appropriate provision for an adjustment of the NHS remuneration of a directly affected doctor or pharmacy owner where it would facilitate a change in dispensing arrangements which the NJC considered desirable.

(10) The NJC should not consider any further proposal or appeal relating to the same area within five years unless it is satisfied that exceptional circumstances have arisen.

(11) Approvals by the NJC should have the following scope:

(11.1) In the case of doctors, be for a defined area, apply to the practice as a whole and be transferable to successors of existing members and to additional members of the practice;

(11.2) In the case of pharmacies, apply to a specified pharmacy and be transferable to a new owner.

(12) The applicant and any doctor or pharmacy owner directly affected by the decision should have a right of appeal to the Secretary of State against a decision of the NJC.

(13) The professions should consider the possibility of payments between doctors and pharmacists being permitted for approved voluntary transfers of dispensing business from one to the other.

(14) To ensure stability until the NJC is established the professions should retain the local interprofessional committees and should agree a further voluntary standstill to be monitored by the local committees, with a central joint body for additional advice.

(15) The professions should jointly request the Secretary of State for Social Services and the Secretary of State for Wales to submit the necessary legislation to Parliament.

¹ *Report of the National Joint Committee of the Medical and Pharmaceutical Professions on the Dispensing of NHS Prescriptions in Rural Areas*, DHSS, 1977.