COMMENTARY

The National Health Industry: costs of complexity

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Over the past few years it has become uncomfortably clear that the National Health Service would perhaps be more appropriately titled the National Health Industry. It is the biggest employer of labour in the country, with about 1 000 000 people working in the industry. And like all major employers it has to cope with the problems of industrial relations—a challenge which is all the more difficult for those in the NHS who have been accustomed to think of themselves working in a totally different environment from that of, say, British Leyland or the coal mines, and who are all the more bewildered when they find themselves caught up in strikes, disputes about overtime, or work-to-rules.

In all this the NHS is inevitably affected by trends evident throughout British society and in all advanced industrial countries. On the one hand, the trade unions are moving beyond their traditional role of seeking better conditions and higher rewards for their members and are asserting their right to take part in policy decisions affecting their members both nationally and in their local work. On the other hand, those sections of the community who in the past have had their right of participation in decisions affecting their work acknowledged—while, like the medical profession, having representation on management bodies and access to ministers—are increasingly adopting trade union tactics in defence of their economic interests. Neither trend is calculated to make for more peaceful industrial relations, as recent events in the NHS have demonstrated, and their convergence is likely to create new conflicts. So the subject of industrial relations—though it has yet to find a place on the medical curriculum—ought to be of concern to everyone in the NHS, and not just to specialists in personnel management or administrators.

Comparatively minor matters like removal expenses, maternity leave, and mileage allowances. But the smooth working of the system is, clearly, of direct concern to the medical profession since grit in the machinery may well mean disputes, loss of morale, or dislocation.

In diagnosing the weaknesses of the Whitley system, the McCarthy report only confirms the verdict of the Guillebaud inquiry² published 20 years ago. The system is too rigid, national agreements give too little scope for local discretion, and the machinery is too slow and complex. There are 43 different staff organisations—ranging from mammoth unions like the Transport and General Workers' to highly specialised professional associations like the Chartered Society of Physiotherapy—represented on nine different councils (one general council, plus eight functional councils for particular occupational groups—nurses and midwives, ancillary staff, administrative and clerical, and so on). Lastly, the views of those who know most about the Health Service—the actual employing authorities at area and regional level—are swamped by DHSS civil servants who sit on—and service—the various councils (and who, the trade unions suspect, take their orders from the Treasury).

No radical solutions

Unfortunately, most of these criticisms of the system spring from weaknesses which cannot be eradicated without changing the structure of the NHS or the balance of power within it. The only full-scale study of the Whitley system previous to the McCarthy inquiry was published in 1957,³ but its final

conclusion is still as appropriate as ever: "Unless the constitutional position of the Minister is changed, or the function of the Treasury is radically altered, or the Health Service adopts a system of full-time governing boards, or the structure of British trade-unionism is completely overhauled, or the Health Service is made financially independent, or several of these things are done, possible changes in the system of collective bargaining in the Health Service are confined within relatively narrow limits."

So it is not surprising that Lord McCarthy—anxious, in any case, to keep within the limits of the generally acceptable—has not come up with any radical solutions but limits himself to tinkering with the existing machinery. In particular, he recommends the creation of regional Whitley councils to achieve more local flexibility and improvements in the way members of the management side are chosen, so as to ensure more direct experience about how the NHS actually works. So far as changes on the employee side of the bargaining table are concerned, Lord McCarthy is extremely cautious. And his caution represents a partial defeat for the trade unions, since the McCarthy inquiry was set up largely because of their dissatisfaction with the machinery and their desire to reduce the numbers of staff representatives by excluding all professional associations. The policy of the TUC, as put to Lord McCarthy, is quite simply that "representation should be restricted to independent trade unions affiliated to the TUC." If accepted this would have meant the exclusion of the Royal College of Nursing (whose membership is coveted by no

continued on page 1464

Relations with trade unions

This is why the report on the Whitley Council system¹ by Lord McCarthy—an Oxford academic specialising in industrial relations—is of general interest. Quite apart from the intrinsic importance of the Whitley Council machinery—which provides the framework for negotiating the pay and conditions of most NHS employees, ranging from regional teams of officers to cooks and laundry staff—the report raises wider questions about the role of the medical and other professions, and their relationship with the trade unions.

The Whitley Council machinery does not impinge much on NHS doctors or dentists, whose pay is determined by the independent Review Body: with the exception of super-annuation, which is partly negotiated through Whitley, its decisions are relevant only over

Hospital practitioner grade

Consultants seek extension

After a long debate on 2 December, attended by the chairman of the General Medical Services Committee, Dr R A Keable-Elliott, the Central Committee for Hospital Medical Services passed the following resolution:

"That the hospital practitioner grade should be open to any doctor who:

- (1) has reached a specified basic level of postgraduate training in the appropriate specialty;
- (2) does not necessarily wish to progress towards a consultant appointment with the associated responsibilities; and
- (3) wishes to work five sessions or less in NHS hospital practice."

The vote was carried by 19 votes to 14.

The chairman, Mr A H Grabham, said that as a result of the vote the committee would no longer be committed to negotiating a new grade for doctors who were not general practitioner principals although it would continue to try to remove the anomalies between the hospital practitioner and consultant scales.

The committee decided to hold a special meeting to consider the BMA's evidence to the Royal Commission on the NHS before it was finally considered by the Council. Thursday 6 January is the planned date.

A report of the committee's proceedings will appear in a future issue.

fewer than four trade unions), among many others.

Though the McCarthy report rejects the principle of giving exclusive negotiating rights to TUC-affiliated trade unions, it also makes some practical proposals which—if adopted—would in the long term weaken the position of some professional organisations. Apart from suggesting that some of the smaller professional associations should commit voluntary euthanasia, the report proposes that in future seats on the Whitley Council should be shared out on the basis of proportional representation—though this is not an immediate prospect, since, incredibly enough, at present no one knows the precise figures of trade union membership. Such a system would exclude some of the smaller professional bodies, deliberately so, since Lord McCarthy takes the view that proliferation ought to be discouraged. Given the trend for new groups of staff to claim professional status, he argues, “the stage is set for continued recognition applications on behalf of smaller and smaller groups.” To permit this, he suggests, would only encourage further “fractionalism and interorganisational conflict.”

Fewer and bigger trade unions?

This is to touch on one of the most difficult and important issues in industrial relations. Should the aim of public policy be to encourage fewer trade unions and, if so, what are the consequences for the members? The arguments for moving towards fewer but bigger unions are strong. Competing trade unions (or professional associations, for that matter) are likely to mean more militancy and thus disruption. This was certainly the experience of the NHS in the early 'seventies when some of the trade unions were quite consciously competing for new members by demonstrating that they could be more aggressive than their rivals. Their tactics were, moreover, very successful in terms of improving the pay of their members. For example, the pay of male ancillary workers—traditionally very low—rose by 131% between 1970 and 1975, while earnings of manual workers in industry increased by only 99%.⁴ And much the same could be said of junior hospital doctors.

But there are also arguments against trade unions or professional associations with monopoly rights. Inevitably this diminishes the freedom of choice for individuals, who cannot shop around for the “best buy” in representation. Nor can those dissatisfied with the performance of their trade union or professional association walk out, join another organisation, or form a new one. In theory it can be argued that if people cannot express their dissatisfaction by “exit” from the organisation they will invest more effort in “voice” to improve it from within.⁵ But in practice there is little evidence that the closed shop is a magic formula for dispelling rank and file apathy. If the danger of competition is that this may breed militancy and so exacerbate friction the risk of a monolithic system is that power will increasingly pass into the hands of unrepresentative representatives: those who are active precisely because they are atypical in their views and the degree of their commitment.

Full discussion needed

The case for discussing these issues fully,

before accepting the McCarthy recommendations for a more streamlined system of representation, is reinforced by another proposal in the report. This is that there should be a three-tier system of consultative committees in the NHS—at national, regional, and local level. The membership of these consultative committees would be chosen on the same principle as the Whitley Council, which is why agreement on eligibility is so crucial. And the committees might consider a wide range of matters from “strategic planning decisions, including the allocation of resources” to “all aspects of the immediate job environment.” In effect, nothing would be barred from their discussions except bargaining about pay and conditions.

The logic of such a development is persuasive. The NHS is an exceptionally complex organisation—in the variety of skills encompassed—and so is exceptionally dependent on the co-operation of many groups. There can be few industries where so many different groups have the ability to obstruct or even veto change: the ratio of driving power to braking power is calculated to promote stagnation rather than movement. Of necessity it is therefore sensible, it may be argued, to devise formal machinery for consulting all those concerned and so attempt to devise policies which will be easier to implement because they are more acceptable.

In reality consultation does not invariably lead to acceptance. Indeed, consultation may even breed extra bitterness because the expectation of those taking part that their views will influence decisions may be disappointed. But even leaving this point aside, participation in the consultative process—like participation in the affairs of trade unions or professional organisations—cannot be taken for granted. Once again there is the problem of rank and file apathy and the consequent danger that the official representatives may in fact be unrepresentative—and may, in the event, be repudiated by those for whom they are supposed to speak.

It is no doubt because of the problem of mobilising interest in consultation that Lord McCarthy rejects direct elections to the proposed consultative bodies and instead argues for representation through recognised staff organisations. In doing so, however, he once more rejects the trade unions' argument that representation should be limited to TUC-affiliated unions. If the trade unions were to drop their attempt to monopolise representation this would certainly remove a cause of much bitterness and conflict—which has contributed to the failure of recent attempts to set up consultative machinery in the NHS. As McCarthy points out the present system of consultation is something of a shambles: “The overwhelming impression I have is that there are more gaps than system.”

Provision for BMA in consultations

But the tactics of the trade unions apart, there are other reasons why staff consultation has so far not made much progress. One of these, the report argues, is the “non-participation of doctors in consultative committees.” Everyone giving evidence to the McCarthy inquiry—civil servants, trade unions, and management—appears to have agreed that “most important issues which a consultative committee could discuss had a medical aspect. It was difficult to discuss these

matters realistically without doctors present.” So the report concludes that “provision should be made for the representation of the BMA on consultative committees.”

This proposal raises more problems than the McCarthy report acknowledges. Implicit in the McCarthy concept of consultation is that the representatives should be able to commit their members to whatever decisions are made. This does not seem to be a realistic assumption in the case of the medical profession. In any event, doctors are already deeply enmeshed in a web of consultation: cogwheels, advisory committees and, additionally, they have their representatives on the district management team. Nothing in the McCarthy report explains how these different aspects of consultation should relate to each other.

Costs and benefits of consultation

But the McCarthy report does at least recognise—if very vaguely—that consultation, like participation in trade union affairs, imposes costs on everyone involved. Thus it may be necessary, for example, to adopt a positive policy designed to help doctors to take part. However, such a positive policy could not be limited to doctors, though it may be that the pressures on their resources of time and energy are the most acute. It is tempting to argue that before committing itself to anything like the McCarthy proposals the DHSS should prepare a budget of the costs and benefits of consultation. On one side of the balance sheet would be the costs of facilitating participation in trade-union and consultative activities: secretarial help, time-off from other duties, extra staff required to cope with the consequent manpower shortage, decisions delayed, and perhaps direct financial help with ballots. On the other side of the balance sheet would be the hope that these costs would eventually be justified by improved industrial relations—an atmosphere conducive to the acceptance of change (not unimportant in the present economic situation).

Given the nature of this balance sheet—where the costs are real and the benefits are speculative—the temptation for the medical profession may well be to dismiss the whole debate as a frivolous, irrelevant distraction from the serious business of patient care. But this would be to ignore an important possibility. Unless doctors can help to improve NHS industrial relations by engaging in a direct, mutually educative dialogue with other sections the consequent ructions and lack of understanding may be even more threatening to the welfare of the patient than the possible time wasted from assuming such a role.

References

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