The Dynamics of Social Partnership in the UK National Health Service

Stephanie Tailby, Centre for Employment Studies Research, University of the West of England

Stephanie.Tailby@uwe.ac.uk

Paper to be considered for presentation at the 47th Annual CIRA Conference/International CRIMT Conference, June 16-18 2010, Université Laval, Québec, Canada

This paper draws on secondary sources and original interview data to review the dynamics of social partnership in the UK National Health Service (NHS) and the outcomes for the parties involved. In the process it engages with parallel academic debates, on partnership in employment relations and, in the public management literature, the transition – or otherwise – to a post-New Public Management phase of public service reform.

New Labour in government in the UK from 1997 made partnership central to its agenda for employment relations modernisation. An immediate effect was to intensify academic debate on partnership’s potential as a union revitalisation strategy. Ackers and Payne (1998) contributed the most optimistic prognosis, although this was on the eve of New Labour’s first (and landslide) general election victory. They proposed that the new political climate combined with the need to legitimate the values and practices of HRM would modify employers’ neglect of (or hostility towards) trade unions. In turn, there would be opportunity for unions to secure their workplace presence, capture the partnership agenda and to play back the rhetoric of employee participation. Against this critics warned that unions’ cooperation with employers risked incorporation in the management of workplace change (Taylor and Ramsay, 1998), membership de-mobilisation (Kelly, 2005) or the unions’ marginalisation in company consultation forums that addressed employer priorities (Danford et al. 2005). Partnership represented at best an unstable arrangement.

To the extent that any consensus emerged in the partnership debate it was that the UK had gravitated too much towards the liberal market economy variety of capitalism to provide a context conducive to a ‘high trust’ reconstruction of workplace relations (Godard, 2004; Dietz, 2010). New Labour offered a partnership fund (until 2004/5) but in respect to the private sector deemed partnership a voluntarist arrangement; it transposed the EU Information and Consultation Directive in weak form (Hall, 2006). In the absence of evidence of any widespread employer conversion, the academic partnership debate petered out from the mid-2000s. Bacon and Samuel (2009) recently attempted to revive its earlier intensity. They argued the debate had eclipsed before the evidence on New Labour’s achievements had been reckoned in full. Their survey of formal union-employer partnership agreements signed between 1990 and 2007 showed the rate of adoption increased from 2000. Once concluded, such
agreements rarely elapsed (formally); employers rarely withdrew from them, although possibly because they were the main beneficiaries. The survey also showed, however, that partnership agreements in the period 2000-7 were largely concentrated in the public sector with the NHS accounting for a substantial share of the total. For Bacon and Samuel (p.243) this showed that in terms of its impact on the take-up of such agreements the Labour government had achieved more as an employer than as a legislator – a point that probably is not in dispute (Martinez Lucio and Stuart, 2002; Tailby et al., 2004). What was not captured by their survey of written agreements, of course, was the significance of those signed, in terms of the configuration of union-employer relations and the outcomes of the partnership arrangement. It is to these issues that this paper turns, with reference specifically to the NHS.

In 1997 and at subsequent general elections, New Labour made improvement in the quality of public services and the efficiency of their production and delivery a high profile commitment. Its approach of public service modernisation (CM 4310, 1999) has been evaluated in a range of academic literatures, although the common issue has been the extent to which it extends or departs from the New Public Management reforms trail blazed by Conservative governments in the UK from the early 1980s. In the public management literature a number of writers argue that New Labour’s approach typifies a shift discernible in other OECD countries, from the NPM to an era of post-NPM or governance (Osborne, 2006; Rhodes, 2007). An ambiguity in such analyses is what has propelled the (putative) transition: the limitations of the NPM (the tendency for its reforms to entrench ‘silos’ in government) and/or the desire of centre-left governments to restore social democracy, albeit in modified form (see e.g. Eliassen and Sitter, 2008). The character of governance can be difficult to pin down: there are different accounts. However, most emphasise the role of central state steering, the involvement of stakeholders in policy formulation, the development of networks that link vertical levels of government and services or specialisms on the horizontal plane, and autonomization of service delivery organisations – to achieve their staffs’ active engagement in innovation and rationalisation on the horizontal plane (Ibid.). There are, of course, critics who doubt that the elements combine to achieve greater efficiency and effectiveness, as proponents of the whole-of-government approach suggest (Pollitt, 2003). And in respect to the UK, observers are quick to point out that central surveillance of service delivery organisations remains in place, so that the latter’s self-governance has involved sticks alongside carrots (Dent 2006).

Healthcare reform universally is challenging for governments (viz. current controversies in the USA, and see Bhatia 2010 on circumstances in Canada). The NHS in the UK is citizens’ most popular public service (the Economist 10/12/2009), the largest - employing 1.5 million people currently (excluding those contracted in) and its workforce is the most densely populated by professionals. New Labour made NHS modernisation a high profile political commitment. A substantial share of the increased public expenditure invested in public services in the period between 2000 and 2005/6 was directed to healthcare which was then subject to more serial restructuring than most public services (Pollitt, 2007). There was initially an attempt to promote cooperation on the horizontal plane; to shift from reliance on contractual relations as the mode of encouraging efficiency savings on the part of the service provider hospital Trusts into which the NHS had been fragmented from 1991, under the Conservative government’s internal market initiative. From 2000 to 2005/6 the
government’s approach was ‘command and control’ (Klein, 2006). The targets and audit system of central government performance management of service delivery organisations inherited from the Conservatives was intensified. The HR targets for service managers included staff involvement and partnership working, which in some instances was the stimulus for Trusts to seek formal partnership agreements with the professional and TUC affiliated healthcare unions. Yet the targets regime was an impediment to employee involvement (Bach, 2004; Tailby et al. 2004) and had other perverse effects (CIPD 2003), for example damage to the morale of front-line employees (e.g. Leveson et al. 2008), obliged to work harder or faster to meet the patient waiting time targets.

At national level the unions were included in a partnership forum with NHS employers and government ministers, that sat alongside a wider, tripartite Public Service Forum created in 2003 (Bacon and Samuels, 2009: 244). With the conclusion of the Agenda for Change national agreement on pay and grading, however, the government’s commitment to the NHS partnership forum appeared to have waned. The unions complained of marginalisation; for example, in 2005 the government announced NHS policy henceforward was ‘choice and competition’ – in effect, the return of the internal market although now with external players – without having informed or consulted the unions (cited in IPA 2008). Rather than have the unions secede, the government revised the national partnership agreement in 2006/7, to provide the NHS Social Partnership Forum with a secretariat and a commitment from government to give early intelligence on policy initiatives (IPA, 2008). An objective for the Forum was to encourage the diffusion of partnership working; there were Trust managements that apparently remained sceptical of its relevance or contribution. The re-launch of the Partnership Forum was followed by the government’s fresh drive to achieve the engagement of front-line staff – in the NHS and public services more generally; that is, their proactive involvement in workplace reform in the interests of productivity and service quality improvement (see e.g. Cabinet Office, 2009). A Department of Health initiative for NHS hospitals, for example, was that of the productive ward, informed by the management literature on lean production techniques.

In reviewing the dynamics of social partnership in the NHS and the outcomes for the parties involved, the paper will emphasise three sets of tensions that are likely to become more acute for whichever political party wins the 2010 general election. First, workforce reconfiguration involving new work practices and a blurring of demarcation lines – as between hospital doctors and GPs, doctors and nursing staff, qualified nurses and health care assistants - has been central to the project of NHS modernisation. The Labour government’s achievements should not be underestimated (see e.g. Entwhistle et al. 2009) and yet need to be set in the context of NHS expansion. That is to say that it is less clear that it is the approach of partnership – as consensual problem-solving – that has been the emollient than the government’s preparedness to pay for change (the Agenda for Change settlement for nurses, the 2004 general medical practitioner contract). There is certainly evidence that employee engagement – or positive embrace of the reforms pioneered to date – remains elusive, possibly because the average doctor or nurse has as yet to experience significant gains in job quality (see e.g. the findings of the annual NHS staff attitude survey). For the immediate future, the resource environment will be more constrained: there is a large public expenditure deficit in the wake of the government’s bail out of the banks and
efforts to counter recession. At the same time there will be greater pressure for NHS managers to achieve efficiency savings and productivity increase.

Second, the IPA’s (2008) review of the national Social Partnership Forum in the NHS suggested it had gained greater influence in government policy formulation and yet observed that among employee representatives interviewed at local level there was a lack of knowledge of the forum or the content of its discussions. There had not, apparently, been much vertical and upwards integration of information sharing and decision-making within the unions’ own structures.

Third, the unions’ involvement at national level nevertheless has been registered by other groups with a stake-hold in the trajectory of NHS policy. Representatives of what Julius (2008) terms the public services industry – that is, the private firms that currently contract for (a substantial volume) of NHS work – articulated suspicion that it was union influence, or at least the government’s desire to keep the unions on side in advance of the general election, that had led to amendment of the rules of competition. In September 2009 the Secretary of State announced that henceforward NHS organisations were to be the ‘preferred provider’ of state funded healthcare and should be given the chance to offer redesigned services before these were put out to tender (Timmins, 2009). Clearly governance is not a conflict-free regime.

References:


