BRIEFING PAPER 13

Flexibility or Fragmentation?

Trends and prospects in nurses pay

James Buchan

King's Fund Institute

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Contents

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Summary

This report was prompted by the current debate on how best to determine nurses pay in the NHS. Increased emphasis on cost control, devolution of managerial responsibility, and the establishment of self governing 'trusts' are key elements of the NHS reforms, and will have a major impact on the way nurses pay is determined.

This report examines the impact of these reforms in terms of the likely labour market effects of local pay 'flexibility', and in terms of the continued existence of the Review Body.

The Review Body, established in 1983, has secured a comparative improvement in nurses pay rates in relation to other groups of NHS employees. If paybill control was the only criteria by which to judge a payment system, then the Review Body system could not be regarded as a 'success' by governments – but fiscal considerations are not the only factor determining public sector pay in a high profile occupation such as nursing.

One potential outcome of pay devolution could be that the pay determination checks and measures in the Review Body system could be removed, and not replaced locally. Local pay determination could then be accompanied by an increased likelihood of local industrial relations problems, if nurses felt disenfranchised from their traditional 'non-militant' pay bargaining methods.

NHS managers interviewed in the course of the study recognised many advantages and drawbacks of the current, centralised pay system. Some were formulating detailed plans for change, which in some cases envisaged a radical move towards 'stand alone' pay determination, with a heavy emphasis on individualised payment. However, most managers regarded changes in the skill mix of the nursing workforce as a first priority, and a major source of cost savings.

Constraints on the pace of change which were noted by managers were primarily resource linked – in relation to funding availability and the existence of sufficient expertise in the personnel function. Indeed, in some NHS units there is an apparent gap between the central impetus for local change, and the local level capabilities to deliver and manage that change.

The limited geographical mobility of many nurses, and the requirement made of many nurses to achieve a balance between career and domestic commitments ensure that the relationship between nurses' pay and labour market behaviour is complex. If pay determination is devolved, many NHS units will have what amounts to a 'captive' local labour market of nurses; where NHS units are competing, managers will come under pressure to limit nurses pay increases by collaborating, formally or informally, with other units.

Whilst the number of NHS units wishing to exercise pay 'freedom' remains small, the Review body can retain its validity, but by 1993–4 a third wave of trusts will be underway. The role of the Review Body will then be seriously compromised, and some fragmentation of the system would be inevitable.

Nurses pay determination has never been simply about pitching pay levels to recruit, retain and motivate. There has always been a tension between political factors (pay more, to assuage public opinion; pay less, to accommodate Treasury and 'taxpayer'), managerial demands (pay enough to recruit and retain, but not more than enough) and trade union and professional demands (pay more, to improve status and secure long term supply of staff).

The Review Body has, in recent years, had to attempt to maintain a balance between those competing pressures. Devolving responsibility for pay determination will not release these pressures, but rather will transfer the burden of maintenance from Review Body to local management. A significant level of pay devolution would undermine the role of the Review Body, and could lead to a net comparative reduction in the NHS nursing paybill. It would not, in itself, 'solve' recruitment and retention problems, and would place considerable demands on local management.

Introduction

1

> *Only if the two fundamental matters of salary and pension are treated on a national basis will the present condition of the profession be improved. We have been impressed by evidence given before us which shows how local authorities and other employing bodies have been forced by circumstances to compete with each other for qualified nurses. This is good neither for the employer nor the nurse, who is encouraged to move from one hospital to another at short intervals, with effects which react adversely on the nurse's work and on her patients* (para. 13) Ministry of Health: Interdepartmental Committee on Nursing services, 1939, HMSO.

> Question *What is a realistic aim for devolution of Whitley and Review Body Authority. What extent of flexibility is feasible and in what time scale?* Answer *Given political restraints complete devolution is still desired for all bodies, (including the Pay Review Bodies). This devolution should be achieved in totality by April 1994 to coincide with the fourth wave of trusts* (NHS Regional Personnel Directors Strategic Meeting, 25th July 1991. Unpublished minutes).

This report was prompted by the current debate on how 'best' to determine pay in the National Health Service. The implementation of the NHS reforms has signalled a change in focus from national to local level pay determination, on the grounds of giving local managers greater freedom and flexibility. Local pay determination, and performance related pay, have also been cited in the Citizen's Charter as a means of securing better staff 'productivity' and quality of service in the NHS.

The reasons underpinning this desire for change can be traced both to political philosophy and to pragmatism. Devolved pay determination, it is argued, frees managers to manage, limits central government interference and will reassert the supremacy of market forces. It could also restrict the effectiveness of the centralised negotiating and lobbying power of the nursing profession, and could distance central government from some of the more politically sensitive aspects of nurses' pay determination. Problematic issues relating to 'trade-offs' between pay increases for different groups of staff and between pay and provision of services would devolve from government politicians and national executive to local NHS management.

In labour market terms, it is argued that devolving pay determination provides local management with greater 'flexibility' in responding to organisational requirements and local labour market conditions. Recruiting and retaining nursing staff is a priority for any NHS unit, and media attention often focuses on nursing 'shortages'. Those in favour of pay devolution argue that pay determination will allow managers to respond more effectively to local staffing requirements and to recruitment problems.

NHS nurses pay is currently determined by an independent Review Body. Whilst there is a political stimulus for pay devolution in the NHS, there is also a publicly stated commitment from both government and opposition to the retention of the Review Body system. The Review Body operates at national level, and recommends national pay rates. Political commitment to the Review Body and political impetus for pay devolution will be difficult to reconcile in practice.

Two key questions will be addressed in this report. Firstly, what labour market and organisational repercussions are likely to arise if a significant level of local pay determination occurs for nurses in the NHS? And secondly, could the Review Body co-exist successfully with significant local pay determination?

The political and economic background

> *Nurses pay is a problem for any government ... The paybill accounts for £3 out of every £100 that the government has to spend. The annual decision on nurses pay is one of the main decisions government has to make, in one of its most public departments* (Clay, 1987).

In total, over half a million qualified nurses, nurse learners and nursing auxiliaries are employees in the NHS. The nursing paybill in 1990–91 totalled £6,098 million, representing one quarter of total NHS expenditure, and approximately 3 per cent of total public spending. Irrespective of the system used to determine NHS nurses pay, the sheer size of the nursing paybill means that control of the system of pay determination and allocation is a priority for any government.

Nursing represents a significant cost both to government and to the taxpayer. The taxpayer, in the guise of 'public opinion', has given little indication of concern. A GALLUP poll, conducted

in 1991 put 'increasing nurses pay' at the top of a list of possible government priorities.

The public image of nursing and nurses has aspects both positive (hardworking and caring) and negative (underpaid and overworked). Nurses pay has periodically been the focus of media attention, a recurring theme being the perceived link between low pay and nursing shortages. Public support for improvements in nurses pay has often been of the emotive 'give them the money' variety beloved of tabloid editorials, but a lack of objectivity has not devalued the political potency of such sentiments.

Successive governments have therefore had to balance professional and public demand for pay increases with Treasury pressure to curtail public expenditure. Another political factor of significance is that nursing is 'women's work' – 93 per cent of NHS qualified nurses are female. One in twenty of the female working population in the UK is a NHS qualified nurse or nursing auxiliary, and the female image of the profession has been cited as an important factor in suppressing nurse pay levels (Salvage, 1985).

Determining NHS nurses pay is not only about achieving a balance between the organisational requirements of management and the demands of unions and other representative organisations. There are contextual political and social pressures which impact directly or indirectly, whatever system of pay determination is in operation. The main pressures acting on the pay determination system are listed in Box 1. Their cumulative effect is to create a tension in the system which has often been difficult to accommodate.

One result of this tension is that nurses pay determination in Britain has, until recently, been characterised by a cycle of years of comparative political neglect interspersed with years of political benevolence, dependant on whether the government of the day had prioritised winning the hearts of the public or pleasing the minds of the Treasury. The result was a 'stop-go' effect of low pay rises in some years, followed by 'catching up' awards in others.

1

PAY PRESSURES

Political	**Treasury and ' taxpayer' considerations – Media/public demands**
Social	**Notions of pay equity and 'fairness'**
Legal	**Equal value considerations**
'Professional'	**Maintaining differentials with other occupations: – Maintain/ enhance status**
Trade Union	**Improve pay and conditions of members**
Managerial	**Recruit, retain and motivate Contain labour costs.**

The establishment of an independent Review Body for nurses' pay, in 1983, can be seen as an attempt to seek another way of accommodating these tensions. The Review Body was intended to be non-partisan, neither directly accountable to the Treasury nor answerable to the public and was promoted by the government of the day as a 'reward' for nurses not going on strike during industrial action in the NHS in 1981/82.

National level collective bargaining was replaced by national level independent review in 1983. A decade later, with increasing pressure for pay 'flexibility' and devolution of managerial responsibility, the focus of pay determination is moving from national level to local level. This report has been written following the implementation, in April 1991, of the NHS Act. The Act is designed to reorganise significantly the structure of the NHS, and provides a framework and stimulus for changes in organisational culture.

Increased emphasis on cost control, devolution of managerial responsibility and the establishment of self-governing NHS 'trusts' are key elements of the reforms, and all will have a major impact on the way nurses pay is determined. This report will examine the impact of these reforms, in terms of the likely labour market effects of local pay 'flexibility' and in terms of their implications for the continued existence of the Review Body.

The first section of this report examines trends in nurses pay. The second section moves on from analysing past trends to examining current plans to restructure nurses pay determination. The third section of the report provides an overview of the labour market context in which NHS nurses' pay is determined. The final section considers future prospects, and speculates on the impact of likely changes in nurses pay determination in the 1990s.

Trends in nurses pay determination | 2

The purpose of the Review Body is to ensure that no one trades on the loyalty of the nursing profession. We are trying to find a fair way to determine their pay ... (Secretary of State for Health, November 1982).

This chapter examines trends in NHS nurses pay, and focuses particularly on the role and effects of the Review Body, since its establishment in 1983. The key characteristics and outcomes of the current system of pay determination need to be examined, prior to assessing the impact of likely changes. Consideration is given to the question – by which criteria should the success or failure of a pay system be measured?

Historical background, 1948–92

NHS nurses pay has always been determined centrally, at national level. From the creation of the NHS in 1948, until the establishment of the Review Body in 1983, the determination of nurses pay was the responsibility of the Nurses and Midwives Whitley Council. Representatives of Staff side (the unions and professional organisations) and Management Side (the Departments of Health and NHS management) met regularly to negotiate pay structures and pay increases as well as to agree other terms and conditions of employment. The review of the Whitley system (McCarthy, 1975) identified a major flaw as being the shadowy nature of government and treasury involvement in the Whitley process – 'the men who really decide are not at the bargaining table' (para.1.15). The 'Management Side' was, and is, an amalgam of two separate parties, memorably summarised as 'employers who do not pay and paymasters who do not employ' (para. 2.3).

The absence of a well defined separate governmental role in the Whitley machinery, and the lack of direct involvement of the Treasury were contributory factors in recurring difficulties in the Nurses and Midwives Whitley Council reaching agreement on pay increases. In many years, control of the paybill and the need to conform to Treasury requirements took precedence over other demands.

In the 1950s and 1960s, the inability of the Whitley Council to reach agreement often led to arbitration or to the involvement of the Industrial Court (the court made eight awards related to nurses pay between December 1952 and 1956) (Gray, 1990). Low pay increases were the end result in a number of years, and there was recurring recourse to special reviews to relieve the tension in the system and to allow nurses pay levels to be improved. There were four such 'special reviews' in the 1960s (Halsbury, 1974).

These 'catching up' exercises can be taken as symptomatic of the difficulties of resolving tensions within the Whitley system, and, as the term suggests, primarily offered redress and a reinstatement of a previous level of 'real pay', rather than any actual improvements in pay, in comparison to other occupations.

The first independent (ie non-Whitley) review of NHS nurses pay was conducted in 1967–8, by the National Board of Prices and Incomes. The NBPI review was followed by other independent reviews in 1974 (Halsbury) and 1979–80 (Clegg). Box 2 shows the key features of each review. Each of these reviews was a one-off exercise, each had an immediate positive effect on pay levels, and the effect of each was then eroded in succeeding years.

This 'stop-go' situation was finally ended in 1983, with the establishment of the Review Body, to 'advise the Prime Minister' on the pay of Nurses, Midwives and Health Visitors (including unqualified nursing auxiliaries, and nurse learners). The Government made the commitment that 'successive governments have agreed to accept Review Body recommendations unless there are clear and compelling reasons for not doing so'. The Review Body, in its first Report (1984) summarised its role as follows:

We are an independent body and our task is to recommend appropriate remuneration for nursing staff in the light of all relevant factors. On the one hand we have an obligation to consider what is fair for the nursing staff themselves. On the other hand we must also have regard to the interests of the taxpayer and to the general economic situation. But the community also has an interest as users of health care in having an efficient National Health Service manned with appropriately trained, experienced and motivated staff (1984, para. 3).

It also stressed its 'major advantage' over previous committees.

We are a standing body, and will be keeping the pay of nursing staff under review continuously from year to year. We shall therefore be able progressively to take account of a wide range of factors including job content and organisation, pay developments elsewhere, and changing economic circumstances (para. 7).

2

NATIONAL REVIEWS OF NURSES PAY, 1968–91

1968	**National Board for Prices and Incomes**	**First independent inquiry into nurses' pay since 1948 – but Board had to observe government pay restraint measures. Broad ranging recommendations to improve 'efficiency' by better deployment of staff and revised staff patterns. Pay increases aimed at increasing differentials, and to combat shortages, in specific areas, particularly at staff nurse level.**
1970	**Whitley Council (Internal Review)**	**Special review which recommended substantial increases in pay – primarily as a catching up exercise. Minor alterations to pay structure.**
1974	**Committee of Inquiry (Halsbury)**	**Second independent inquiry. Concluded that nurses pay had 'fallen behind' other occupations since 1970. Proposed significant increased in pay to 'catch up', and to combat staff shortages. Proposals to 'simplify' pay/grading structure.**
1980	**Standing Commission on Pay Comparability (Clegg)**	**Third major independent review of nurses' pay. Used factor analysis job evaluation in formulating its recommendations. Recommended a reduction in working hours to 37.5 hours per week, noted pay levels had fallen since Halsbury, and made recommendations for major pay uplift. Also voiced concern about danger of future erosion of its recommendations.**
1984–current	**Review Body**	**Annual recommendations on pay levels, from 1984 onwards. Takes evidence from Management and Staff sides of Whitley council. Government committed to implementing recommendations, unless there are 'clear and compelling' reasons otherwise. Review Body deals only with pay.**
1987–8	**Clinical Grading Review-Whitley Council (Internal Review)**	**Used job analysis to establish a new pay/grading structure for clinical grades. This structure was then 'priced' by the Review Body.**

The Review Body receives evidence from Management and Staff side of the Whitley Council, but makes its own, independent recommendations on nurses pay which the government is committed to implement – unless pleading 'clear and compelling reasons'. The Review Body system enables a long term view of nurses pay to be developed, and eschews some of the features of the Whitley system – it is not directly cash limited, it cannot be readily disrupted by delaying tactics, and it is not directly answerable to the Treasury. The competing demands of different government departments, unions and managers, inherent in the determination of NHS nurses pay, have now to be resolved by the Review body.

The Review Body system has been described in some detail by one of its members (Thomason, 1985), who concluded:

> *The pay review bodies have been established to exercise judgement, in order to determine what shall be the pay levels of groups of workers who find themselves in rather particular market circumstances. What they must do is exercise that judgement fairly, taking into account what all the interested parties draw to their attention but avoiding any slavish acceptance of any one view or argument. They are not in business of doing simple sums or of applying simple formulae and their conclusions must inevitably be reached as an outcome of long debate and discussion.*

The next section will examine pay trends, in order to illustrate the impact of the various reviews of nurses pay conducted in the last twenty four years, and to assess the impact of the Review Body on nurses pay levels.

Pay trends

Analysis of pay trends is usually an inexact science, and often a partisan exercise. Choice of starting dates, selection of comparator groups, definitions of 'pay', 'salaries' and 'earnings' can vary, as can interpretations of results. This section aims to highlight key trends and events in the recent history of nurses pay determination; it does not attempt a detailed 'objective' analysis of the data.

Long term trends

Since the establishment of the NHS in 1948, 'real pay' of nurses (i.e. pay in relation to inflation) fell back in the 1950s, exhibited little improvement through the 1960s, and increased most markedly in 1974 (Halsbury report), fell back and then increased in 1979–80 (Clegg report), fell back and

then increased again from 1986–8 (Review Body/ clinical grading) (Gray, 1989).

Pay relativities within NHS nursing have fluctuated over the period since 1948. Relativities between staff nurse and sister grades widened in the 1960s, and staff nurse pay levels have remained at 70-80 per cent of ward sister pay in the 1970s and 1980s. Nursing student pay exhibited a relative fall in relation to qualified staff in the late 1950s and 1960s, a relative increase through the 1970s, and a relative decline in the 1980s.

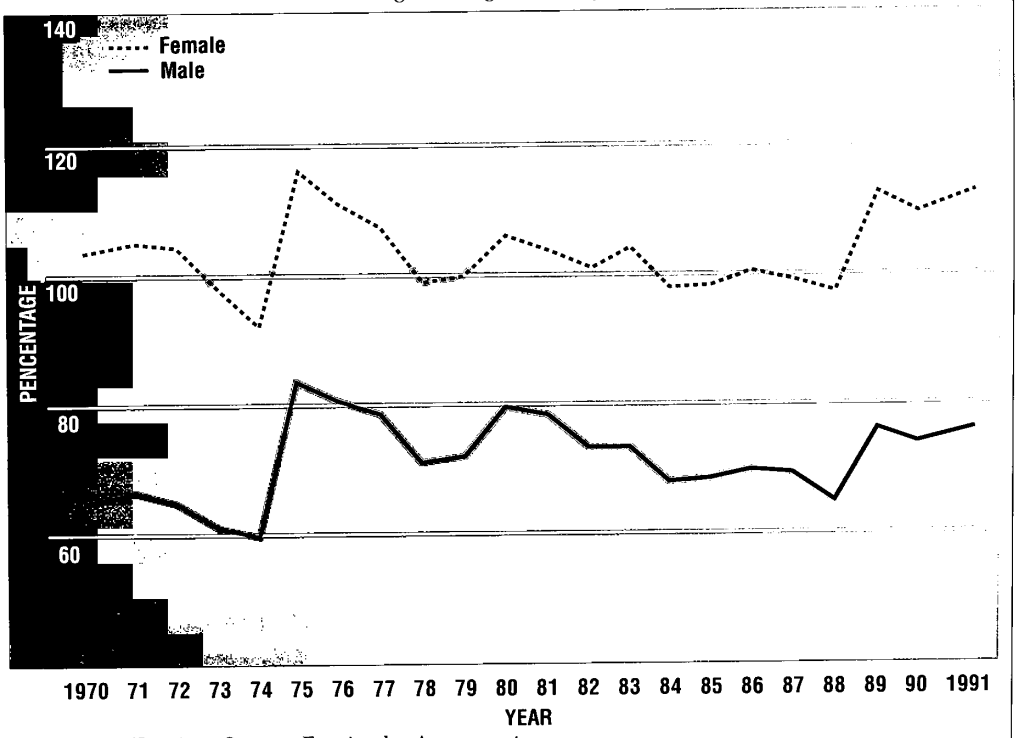
Figure 1 illustrates trends in the average earnings of male and female full time nurses, in comparison to average non-manual earnings in the economy from 1970–91. Female nurses earnings have fluctuated around the female non-manual average over the time period, with nurses experiencing comparatively high earnings increases in 1974–5 (Halsbury), 1979–80 (Clegg) and 1989 (clinical grading). The comparative erosion of earnings levels after the Halsbury and Clegg awards is also evident. With the exception of the upturn at the time of the clinical grading award, the period of the Review Body appears to be one of comparative stability although not without some year on year fluctuations. A similar pattern is revealed in the trends in male full time nurses earnings, but male nurses earnings have fluctuated around 70 per cent of male average non-manual earnings.

Comparison of NHS nurses earnings with the earnings of other NHS employees is shown in Figures 2 and 3. Both figures illustrate a similar trend over the period 1970–91, and are of interest because they compare nurses earnings movements with two NHS groups whose pay has continued to be determined by the Whitley system – administrative and clerical employees, and ancillary employees.

Female nurses earnings, as a percentage of female NHS administrative and clerical workers earnings (Figure 2.3) fell back in the early 1970s, and again in the years after Halsbury in 1974–5 and Clegg in 1980, but increased over the period of the Review Body (particularly during clinical grading 1987–8) before falling back slightly in 1989–90. Female nurses have experienced a comparative improvement in relation to earnings of NHS administrative and clerical staff, over the period since 1970. A similar, if less pronounced pattern is evident in Figure 2.3 which compares the earnings of male nurses and male ancillary workers.

These long term trends in nurses earnings over the period 1970–91 illustrate both the

Figure 1 Nurses earnings 1970–91. Male as a % of male non-manual average earnings, female as a % of female non-manual average earnings (£ weekly).



Source: New Earnings Survey, Earning by Agreement

Figure 2 Female nurses earnings as a % of female NHS A&C earnings (£ weekly) 1970–91

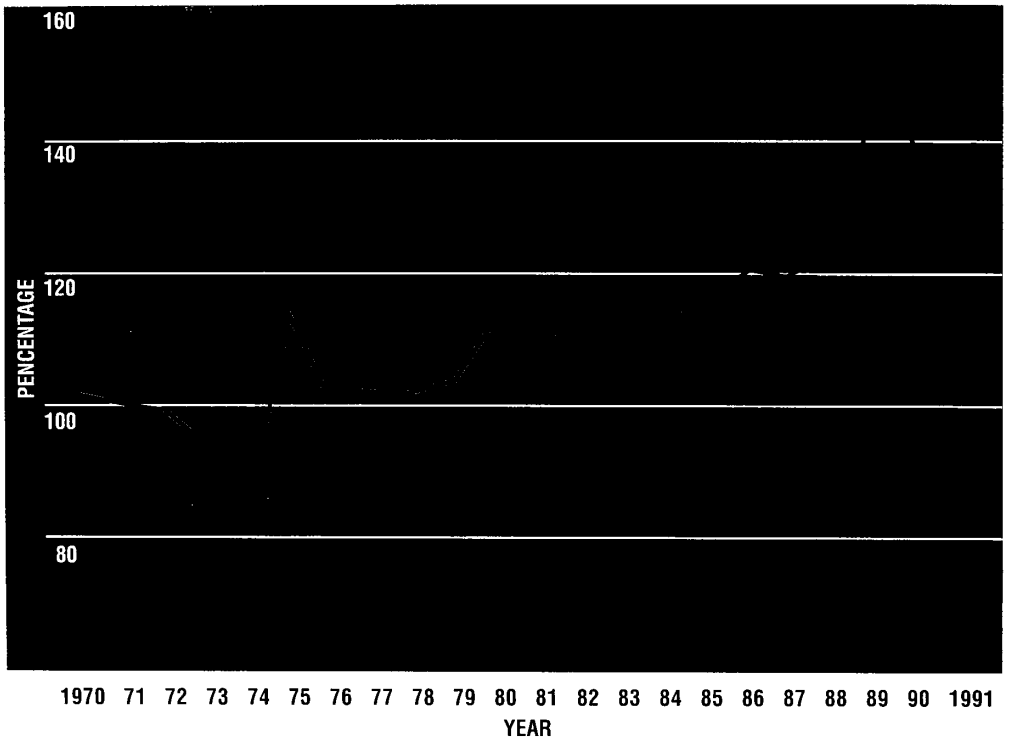
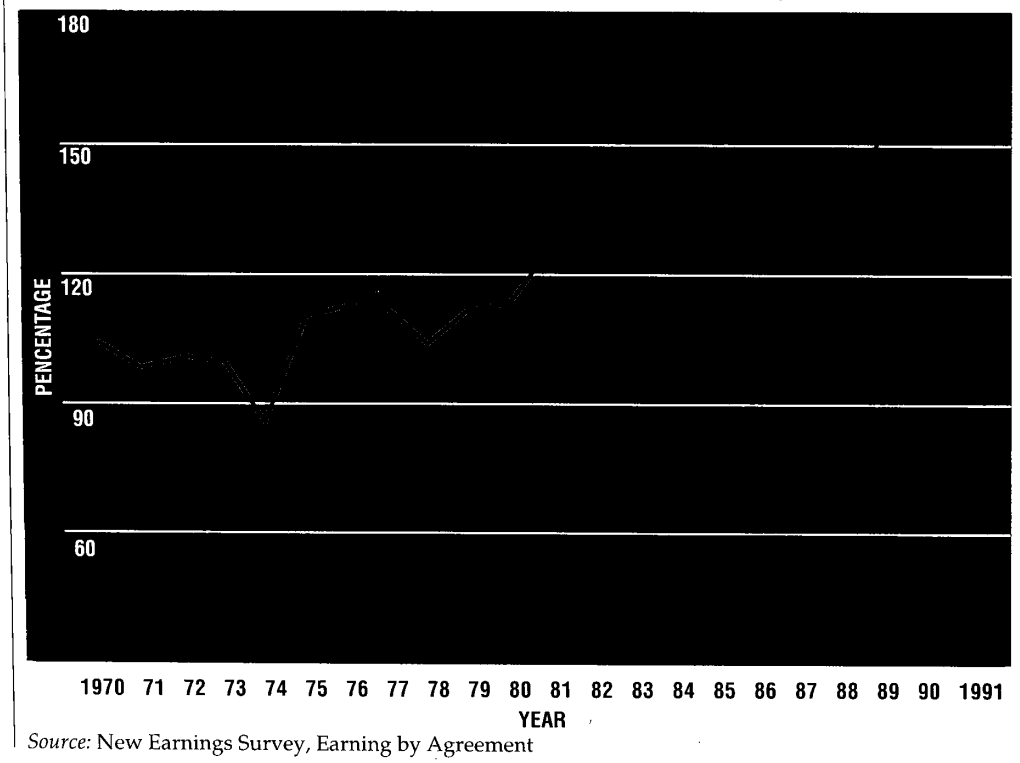


Figure 3 Male nurses earnings as a % of male NHS ancillary earnings (£ weekly) 1970–91



Source: New Earnings Survey, Earning by Agreement

fluctuations in comparative earnings levels which were evident in the 1970s and early 1980s, and the period of comparative stability which has occurred in the second half of the 1980s.

Review Body Awards, 1984–92

The Review Body was established in 1983. It has followed an annual cycle of work, receiving and reviewing evidence late in one calendar year, and forwarding its recommendations to government and publishing its report in the following year, with an implementation date of April 1st. The main issues which it considers are listed in Box 3.

The Review Body has stated that it will take account of information available to it up to December of the year preceding the year of recommendation. It has also acknowledged that this will lead to some fluctuations, which will 'even themselves out' from year to year (1990, para.3).

Table 1 lists the overall recommendation of the Review Body in each year since 1984, based on its assumption of increase in the total paybill. For comparison, the underlying trend for earnings in October–December of the year previous to each award is shown as one indication of the information available to the Review Body whilst formulating its recommendation. A close comparison is apparent in many years, with some exceptions (eg 1988 – clinical grading). Similarly, there has often been a close comparison between Review Body recommendations and the subsequent annual average increase in earnings for non manual employees.

It could be argued that the Review Body is a complex and time consuming mechanism for pitching nurses pay awards near to the increase in average earnings. The indexation of police and firefighter pay, using formula linked to increases in earnings, can be cited as working examples of public sector pay determination without recourse to independent bodies. However, the main additional feature of the Review Body is its independence and the fact that its response can be flexible – it is not an automatic mechanism. It can decide to recommend increases in any one year that are markedly at variance with the 'going rate'.

As noted in the previous section, the key determinant in the success of the Review Body system is that the government should fulfil its

3

MAIN ISSUES CONSIDERED BY REVIEW BODY

'affordability'	**economic and financial considerations**
recruitment and retention	**vacancy rates, turnover statistics and intakes to nurse education are reviewed, and long term indicators considered.**
'fairness and comparability'	**pay and earning/data in the NHS and elsewhere are reviewed.**
morale and motivation	**general consideration given to issues related to job satisfaction. Little relevant data available.**
productivity and workload	**indicators of 'productivity' and changes in workload of staff are reviewed. Minimal data available.**

Table 1 Review Body recommendations

Year	Review Body Recommendation %	Underlying Trend in Average Earnings, October–December of previous year[1] (O)	(N)	(D)	Actual Annual Increase in Non-Manual Average Earnings in year from April[2]
1984	7.5	7 3/4	7 3/4	8	8.2
1985	8.6	7 1/2	7 1/2	7 1/2	7.6
1986	7.8	7 1/2	7 1/4	7 1/2	9.0
1987	~~6.8~~ 9.5	7 1/2	7 3/4	7 3/4	8.6
1988	15.3[3]	8	8 1/4	8 1/2	11.0
1990	9.6	9 1/4	9 1/4	9 1/4	9.9
1991	9.7	9 3/4	9 3/4	9 3/4	8-9?
1992	5.8	7 1/2	7 1/2	7 1/4	
~~1989~~	~~6.9~~	~~9~~	~~8 3/4~~	~~8 3/4~~	10-2

(1) Department of Employment Gazette, various;
(2) Department of Employment Gazette, September 1991, Figure for 1991 is an assumption.
(3) Review Body estimate.

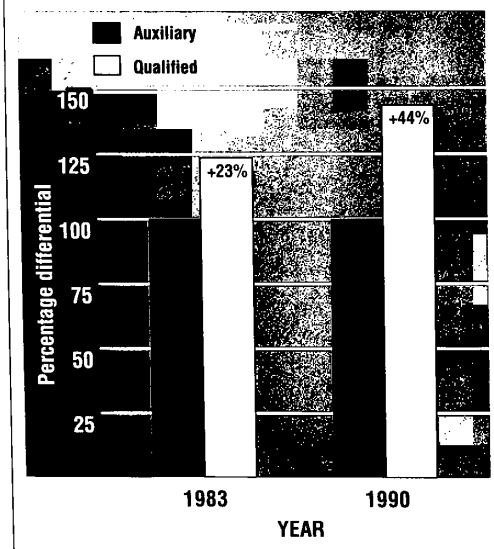
commitment to fully implement these recommendations. In practice, the government has 'staged' or delayed full implementation in four of the nine years that the Review Body has been reporting. Table 2 shows the main issues to which the Review Body gives consideration.

In these four years the government has trodden a fine definitional line – it can claim to have 'fully implemented' by the end of the year in question, but 'staging' or delayed implementation means it has reduced the annual paybill costs by several tens of millions. In these years, paybill control has taken a precedence. The tension between accommodating public opinion and assuaging the Treasury continues to be a political factor. 'Staging' has tended to occur in non-election years.

The Review Body's own measure of its impact was published in the 1991 Report, where a graph showed an uplift achieved by clinical grading in April 1988, and also illustrates the effect of 'staging' in several years. Over the period covered since 1983, the increase in nursing staff earnings was shown to have broadly matched that of the average earnings index, with a comparative improvement being most marked in 1988. (Ninth Report).

Figure 4 shows that qualified nursing staff have experienced higher increases in earnings over the period of the Review Body than have unqualified nursing staff. Unqualified nursing auxiliaries have not received the same level of earnings increase over the time period, and pay differentials between qualified nurses and nursing auxiliaries have widened.

Figure 4 Earnings differential – female nursing staff: auxiliaries and qualified nurses weekly earnings, 1983 and 1990.



Source: New Earnings Survey, earnings by occupation

Table 2 Review Body Awards, 1984–92

Year	Extent of Implementation
1984	Fully implemented
1985	Staged by Government, fully implemented February 1986
1986	Delayed by Government, fully implemented June 1986
1987	Fully implemented
1988	Fully implemented
1989	Fully implemented
1990	Staged by Government, fully implemented January 1991
1991	Staged by Government, fully implemented January 1992
1992	Fully implemented

Clinical grading

The pay/grading structure for NHS nurses remained basically unaltered from the establishment of the NHS in 1948 until 1988. In that year a new clinical career structure was implemented, with new grads being 'priced' by the Review Body. The career structure itself, and the criteria used to determine grading were developed and agreed by the Nurses and Midwives Whitley Council after the work of external management consultants had proved unacceptable to both sides.

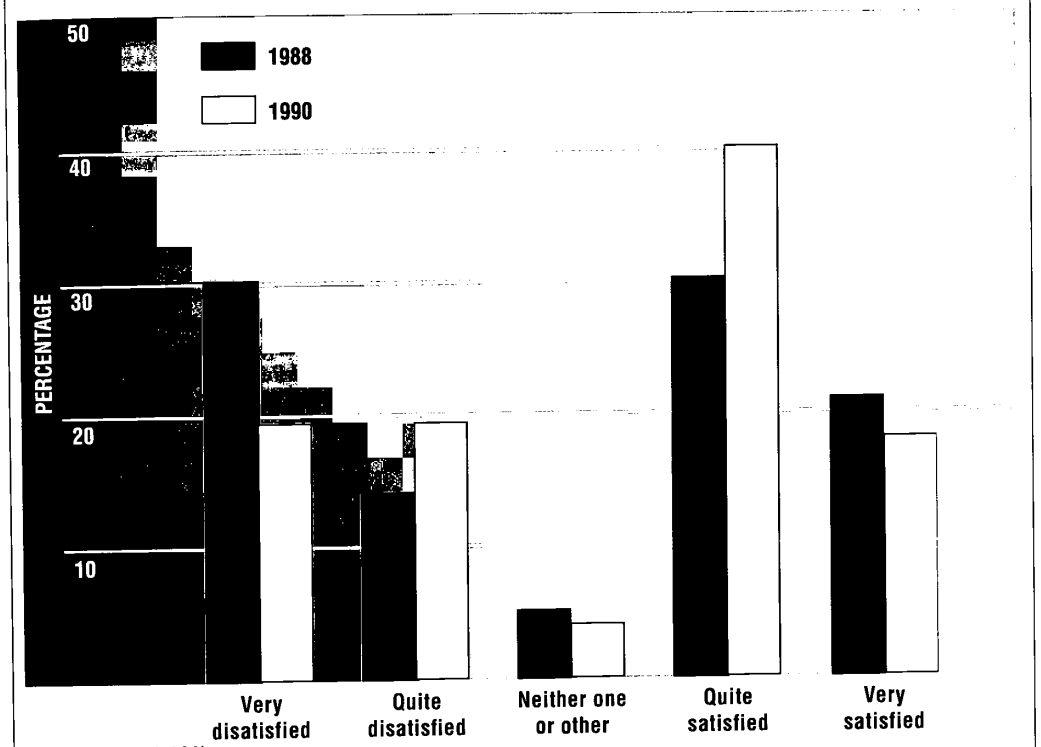
The implementation of clinical grading was not without problems (see Beardshaw and Robinson, 1990), most of which were predictable, given the magnitude of the exercise and the potential difficulties of fully funding the exercise (Buchan, 1988). Applying differential pay increases to individual nurses at local level caused discontent, and differences in interpretation of criteria or in application of grading created varying patterns of grading outcome in different employing units. The result was that many NHS nurses appealed against their grading outcome and entered an appeals procedure not designed to cope with the actual numbers of appellants.

In its 1992 report, the Review Body noted:

> *"Over 30,000 appeals arising from the 1988 clinical grading review are still waiting to be heard. Dissatisfaction about the backlog has infected the attitude of many staff to the pay scales themselves"* (para. 12).

The Review Body was critical of some management involvement in the initial grading process (1989, para. 5). Figure 5 shows survey evidence of

Figure 5 Satisfaction with clinical grading RCN qualified nurses, 1988 and 1990.



(N = approx 3,000)

Source: IMS/RCN

individual qualified nurses which suggests that approximately 30 per cent were very dissatisfied with their grading outcome in 1988, whilst a more recent 'follow up' survey suggests an overall improvement, with a higher proportion of nurses expressing satisfaction with grading, and fewer indicating extreme dissatisfaction.

Overview

The 'Whitley period' from 1948–83 was one of marked fluctuations in the comparative rates of pay of nurses, with internal 'special reviews' and external one-off independent commissions being required to maintain real pay rates, or facilitate catching up exercises. The 'Review Body period' from 1983–4 has been characterised by less fluctuation and greater consistency in nurses pay movements in comparison to general movements in earnings. The Review Body has tended to exert a dampening effect on pay fluctuations, and over the period of its existence has secured a comparative improvement in nurses pay rates in relation to other groups of NHS employees. However, this improvement has not been achieved without some fluctuation across the time period, with the clinical grading review in 1988 being best regarded as a one-off 'improving' award. In many years, 'indexing' of pay awards to general increases in earnings would have achieved a similar result. The additional flexibility of the Review Body system has been the facility to buck the 'average' trend in specific years. In some years (eg 1988) it has awarded higher than average increases.

Given the different, and often competing pressures which act on NHS nurses pay determinations, it is difficult to identify generally acceptable core criteria by which the 'successes' or 'failures' of the two national systems – Whitley collective bargaining, and Review Body – can be evaluated and compared. From the perspective of the Treasury, 'success' is measured by tight control of the paybill, and by this measure, the Whitley system was more open to control than is the independent Review Body. From the point of view of local managers, both systems have an inherent flaw – there is little scope for direct involvement by operational management in the pay determination process. After some initial hesitancy by some unions (eg. COHSE) the various unions which represent nursing staff have generally been in favour of the Review Body, recognising that it has achieved some comparative improvements in pay for their nurse members.

It should be noted however that these improvements have been most pronounced in comparison to other groups of NHS employees where pay has continued to be determined by Whitley rather than in comparison to other non-NHS occupations. They have also occurred in a decade in which inflation was on average much lower than in the previous decade, and in which the industrial relations climate and legislation was not conducive to aggressive collective bargaining by unions.

In many ways, from a union point of view, the Review Body system proved to be tailor made for the public sector industrial relations of the 1980s, and was particularly suited to the requirements of the biggest union representing nursing staff – the 'no-strike' Royal College of Nursing. The main criticism which some of the unions – NUPE and COHSE – could make of the Review Body system is that internal pay relativities between qualified and unqualified nurses have increased, leaving their unqualified nurse members at a comparative disadvantage.

If paybill control is the only criteria by which to judge a payment system then the Review Body system cannot be regarded as a 'success' by the government – but fiscal considerations are not the only factor determining public sector pay in a high profile occupation such as nursing. In the long term, at least, broader concepts of 'fairness' and pay equity have to be accommodated, and sufficient recruits to the profession have to be encouraged.

Equally, the current move towards pay devolution in the NHS can only be a success for government if fiscal control is maintained or improved. If control over the absolute level of funding is retained at national level (which, by definition can occur as long as the centrally funded National Health Service exists), but decisions on how that funding is to be allocated are devolved to local level, then the responsibility for resolving the need for 'fairness' would rest primarily with local management.

Whilst it can be argued that the 'best' level for pay decisions is at the point of delivery, it is unclear if all local managers have fully realised what NHS pay devolution would entail. The 'freedom' to determine pay levels would be cash limited, and could bring with it additional, and unforeseen responsibilities. The 'freedom' to pay more is also a freedom to pay less, and to pay employees individually rather than collectively.

One potential outcome of devolution could be that the pay determination checks and measures contained currently in Whitley and the Review Body could be removed, and not replaced locally. Local pay determination could then be accompanied by an increased likelihood of localised labour relations problems, if nurses felt disenfranchised from their traditional 'non-militant' pay bargaining methods and mechanisms. The difficulties experienced at local level during clinical grading serve as an example of what could occur if a move to local pay determination was mismanaged. One NHS manager has noted that the Review Bodies 'at least have helped the service to avoid conflict over the pay of professionals. Under a more decentralised system an effective means of settling local disputes without recourse to industrial action will have to be found' (Fillingham, 1991).

Much of the stimulus for NHS pay devolution has come from the centre; and has focused on achieving a change in organisational culture: As the Deputy Director of Personnel at the NHS Management Executive noted:

> *We were seeking to change the culture of an organisation with 1 million employees and a forty year history of central prescription and control We needed to energise large numbers of managers, to challenge many vested interests and seek to win the hearts and minds of our staff despite the external pressures* (Johnson, 1991).

The next chapter will focus on managers at the local level. In what ways have they been 'energised', and what are their plans for nurses pay determination?

Plans for nurses pay

3

We discovered earlier, when we discussed pay principles, that management in particular had a terror of anomalies (McCarthy, 1978).

We thrive on anomalies
Trade Union Official, interviewed in June 1991

This chapter assesses the plans for nurses pay determination in the 1990s in the context of organisational change and in the light of changing labour market pressures. What are managers at local level actually planning? What were the pressures and priorities shaping these plans? The chapter draws on structured case study interviews with managers in 23 trusts and directly managed units, and on discussions with representatives of three of the major trade unions representing nursing staff – RCN, COHSE and NUPE.

Current recruitment difficulties

In order to identify current labour market pressures and priorities, case study participants were asked to indicate if they were experiencing any difficulties recruiting nursing staff. (Box 4 gives details of the participants.)

The general response was that recruitment difficulties for qualified nursing staff had eased over the period since 1988–9, due to the relatively high pay awards in the first year of clinical grading, due to the impact of general economic recession ('high interest rates have squeezed more nurses onto the labour market', stated one respondent) and because of claimed success with local 'non pay' recruitment and retention initiatives. It is not possible to evaluate the extent to which these factors are causally linked to a downturn in mobility and turnover rates, but there is evidence to suggest that turnover rates have reduced, at least in some areas, in the late 1980s (eg South West Thames RHA, 1991) vacancy rates, as reported by the review Body, have also fallen in 1990–91. However, in most case study sites there continued to be reported recruitment difficulties for specific grades or specialties.

Some of the problematic specialties reported by case study respondents are listed in Table 3. The main problems were with 'high tech' areas in theatres and intensive care – with many respondents suggesting that a national shortage of specialist trained staff was the root problem, and with the less glamorous 'cinderella' services in mental handicap and mental illness, where

4

THE CASE STUDIES

Personnel and/or nurse managers in 15 directly managed units (including a number who planned to be second wave trusts) and 8 trusts were interviewed, using a structured discussion guide. Case study sites were randomly selected to reflect varying labour market conditions as shown below.

CASE STUDY SITES

Region	Trusts	DMUs
North West Thames	–	1
South East Thames	–	2
South West Thames	2	1
North East Thames	3	1
Wessex	1	2
West Midlands	–	2
Yorkshire	1	2
Mersey	1	–
Trent	–	1
Scotland	–	3
TOTAL	8	15

The aims of the case studies were to generate information on local level plans to modify or replace the current system of nurses pay determination, and to identify the rationales underlying any proposed or planned changes in the system. Case studies were conducted in Spring/Summer of 1991.

Table 3 Case Study Sites: Reported recruitment difficulties

Specialty	N=
theatre	11
intensive care	5
special care baby unit	3
paediatric	3
mental handicap	3
mental illness	3
health visiting	3
renal	2
orthopaedics	1
ophthalmology	1

recruitment has often been comparatively difficult. Respondents in the South of England were more likely to report recruitment difficulties than those in the North, often citing housing costs as a specific local problem, in addition to any 'national' difficulties.

The small sample size of case studies precludes any interpretation of their reported recruitment difficulties as an indicator of the 'national' state of nursing recruitment and retention. There was no evidence of widespread shortages, but rather at local level it is apparent that there were often problems with recruiting some specialties of staff, and these problems could relate to national and/or local factors.

The current system of nurses pay determination

Respondents were asked to indicate what benefits and drawbacks they perceived in the main elements of the current pay system (i.e. Review Body and clinical grading). A summary of responses is listed in Box 5.

Most management interviewees could see both positive and negative features to the Review Body system. Perceived benefits included the lack of requirement for local level managers to become involved in time consuming and potentially disruptive pay determination, and a recognition by some managers that individual nurses regarded the current system as 'fair'.

Reported drawbacks related to the Review Body's perceived 'isolation' from the local level, the lack of influence which local management felt they had in the pay determination process, and differential pay awards between 'Review Body' staff and 'non Review Body' staff (including, it has to be said, most of the interviewees) leading to higher pay increases for those covered by the Review Body system.

Clinical grading also generated a mixed response from case study sites. Two main drawbacks were reported by respondents. The first related to the grading criteria, which some managers regarded as inflexible and prescriptive. The second concern was about the initial implementation of the grading review, which some respondents regarded as having been flawed. Reasons cited for inadequate implementation included: 'inept management' in some areas; unrealistic expectations by individual nurses of grading outcome; and, the heavy workload for managers caused by the high level of grading appeals in some authorities which had damaged staff morale.

The optional third element of the pay system – the flexible pay scheme managed by the Department of Health – had been used by six case

5

CURRENT PAY SYSTEM: REPORTED BENEFITS & DRAWBACKS

BENEFITS	DRAWBACKS
Review Body	
independent, impartial	isolated
'takes the industrial relations out of pay determination'	doesn't relate to local labour market
'lack of hassle' for local managers	not accountable
	local management not involved
perceived as 'fair' to nurses	'unfair' to non Review Body staff
more likely to be fully funded than Whitley	no control over paybill costs
Clinical Grading	
'some limited flexibility'	too rigid
'forced us to look at jobs nurses do'	'destroyed industrial relations in nursing'
'helped in recruitment'	'criteria too prescriptive'
'provides a framework for grading'	ongoing appeals creating difficulties
doesn't reward advanced clinical skills	

Source: Case Studies

study sites. Two of the six indicated it was too early to assess the impact of the flexible pay scheme, two believed it had been effective, one was unsure, and one respondent (a trust) indicated 'there was nothing to suggest it [flexible pay supplements] was appreciated, and no evidence to suggest it affected recruitment and retention'. Respondents who were eligible, but had not participated in the scheme either suggested that a lack of recruitment problems had made an application to the scheme unnecessary, or indicated that they did not regard the scheme, as constituted, to merit participation. The director of personnel in one trust noted: 'the problem is that as a system to provide flexibility to meet local labour market needs it's a dead loss, it's far too inflexible. It's no use people sat in London deciding these things once a year.' Another commented that: 'selective supplementation merely shifts nurses from one job to another'. In its 1992 report, the Review Body noted that monitoring of the flexible pay scheme by the Department of Health was inadequate 'to reach any worthwhile conclusion on the adequacy of the supplements' (para. 18).

In overall terms, the current system of determining nurse pay was regarded as flawed by most respondents. Equally, however, most recognised that the current system had some merits. The drawbacks in the system tended to be characterised in terms of a lack of local involvement and 'flexibility'; conversely some of the perceived benefits also related to a lack of local involvement – some respondents felt that the Review Body took the burden of pay negotiation off the shoulders of local managers.

A minority of respondents considered the system sufficiently flawed to do away with completely, but most recognised intrinsic merits which they wanted to see retained in any future pay determination system.

The future pay system

Planning

Respondents were asked to outline what form of nurses pay determination would best suit the resourcing needs of their own organisation. Responses can be broadly grouped in two categories. The first group (a minority) envisaged radical change, with significant movement away from the current system, within a limited time-scale of between two and five years. The second group (the majority) indicated that they would wish to see greater scope for local flexibility, but within a looser national framework.

The first group of respondents were mainly directors of personnel in first wave trusts. Some of these respondents were considering a 'one off' complete departure from Whitley terms and conditions, with pay for all staff being consolidated on a single 'pay spine' for all employees. This 'big bang' approach was being evaluated in a small number of sites, but there was some concern expressed at the potential costs of assimilating all staff into a single structure, and doubts about a system which would allow the pay of 'other' staff (eg ancillary and administrative employees) to be 'dragged up' along with that of nurses and doctors. At the time of writing a small number of trusts are planning to implement such a pay scheme (see also Industrial Relations Services, 1990).

Other respondents in this first group were also planning for radical change, but on a more incremental basis, with a phased substitution of local level, individualised pay for national level, collectively determined pay. This approach was regarded as having three major merits. First, it was less likely to stimulate union opposition than a 'big bang' approach. Second, it could more easily accommodate future changes in organisational policy, or in political priorities. Finally, it was more readily achievable with the resources available.

Managers following this incremental approach to change were focusing their attention on identifying methods of restricting the impact of national pay awards, and relating future pay increases to trust business plans. This could be achieved either by 'individualising' a greater element of the pay package of staff (often by implementing a performance related pay [PRP] scheme) or by paying specific key posts on non-national rates. Plans, cited by some respondents, to redesignate ward sister posts as 'ward managers', with budgetary responsibilities, was regarded as one means of achieving this objective. Many of these managers were planning to offer non-Whitley terms and conditions to 'new' employees (current employees having the legal right to remain on Whitley terms when trusts became self-governing).

Some form of performance pay (PRP) scheme was being considered, or being implemented, in a number of these sites (see Hodges, 1991). A variety of schemes were under consideration, some adapted from other industries and others based on that currently used for NHS general managers. A number of respondents indicated that they were considering some form of 'team based' performance pay system. However, at the time the case studies were conducted, none of the respondents considering PRP – be it individual, or team based – had yet implemented a scheme. Benefits of PRP were perceived to relate to achieving a change in organisational culture, as well as motivating and rewarding individual performance.

Many of these respondents were also considering 'simplifying' the nurse pay structure. Some units were proposing to remove unqualified staff from the same pay determination system as qualified nurses. Reductions in the number of grades were also being actively considered. One

trust was proposing to 'merge' clinical grades C and D, another was proposing to delete grade D.

This incremental approach to securing significant change (in some instances apparently verging on the opportunistic) was flexible and not irreversible in the short term. It was also perceived as having the benefit that it could be 'sold' to suspicious staff and unions as something less radical than it actually was, by focusing their attention incrementally, on short term minor changes rather than on a longer term agenda for major change. In practice, for the first year or two of implementation, many units following this 'evolutionary' approach to more radical change would not differ markedly in terms of employment practice from units planning only minor variations from Whitley. Two recent surveys of trust pay determination plans (COHSE, 1991; Industrial Relations Services, 1990) which focussed on written documentation revealed little sign of immediate or radical change. It is evident from discussion with trust respondents that some have a 'semi-hidden' agenda for greater change.

The second grouping of respondents – the majority – were mainly those in directly managed units and were generally in favour of less radical change to the current pay system. They tended to characterise their desire for change in terms of increased 'flexibility' – an increased ability to award additional supplements or increments to hard to fill posts, or to hard working individual nurses. Some of these management respondents regarded a radical departure from the current system as undesirable (because of resource implications), impractical (because 'it wouldn't work') or unnecessary (because the current system was not sufficiently broken to require mending). A few managers even regarded it as potentially dangerous: 'If we do away with the Review Body it would be bloody anarchy'; 'The worst possible thing would be a totally decentralised system'; 'one of the great risks of devolution is disequilibrium'.

In overall terms, the responses from the 23 case study sites reveals a broad range of opinion on the future shape of pay determination for nurses. All respondents agreed the current system was flawed, but not all thought it required radical changes, and comparatively few suggested it should be completely replaced.

It is also important to stress that, at the time of the case studies, plans for change were often at a comparatively early stage of development, and some respondents admitted that early enthusiasm for radical change was being tempered rapidly by a recognition that the practicalities of implementing these changes would be time consuming and daunting. ('There are a lot of sheep in wolves clothing out there', commented one personnel manager.) It is perhaps significant that the trusts which have implemented, or appear to be planning, the most radical changes tend to be smaller and `simpler' in terms of staffing numbers and mix – for example the ambulance trusts (eg Northumbria), and community based or priority service units (eg West Dorset community; Homewood Trust).

No trust or directly managed unit is a 'greenfield site' on which a new industrial relations culture and pay determination process could be set up on April 1st 1991. Organisational status may have changed on that date, but the organisational politics, the personalities and the local industrial relations custom, practice and history remain. As one respondent noted, 'You don't change 40 years of NHS history overnight'.

Constraints on change

Four possible constraints on achieving change in the pay determination system will be considered. These are funding, industrial relations, staffing the personnel function, and labour market conditions.

Funding

The 'purchaser/provider' split, which was a central plank of the NHS reforms, has had the effect of concentrating the minds of personnel managers in 'provider' units on labour costs. With three quarters of the running costs of most units relating to the wage bill, tight control of salaries was being regarded as one way of obtaining a competitive advantage in bidding for contracts from purchasers.

Many respondents noted that cost containment would remain a key issue in healthcare funding, and in a cost conscious environment it was likely that any new pay structure would have to be self financing. Respondents recognised that this would limit their options for action; some believed that radical change could not be achieved without additional funding from central sources. One trust director of personnel noted, 'I'm concerned about the ability to fund any dramatic changes. Funding can only come from purchasers and their money comes from the government – we will have to be as mean as we ever were.'

One management commentator has noted:

> *Managers might decide to remain within the existing system of national level collective bargaining. Unless they can raise the income which allows them freedom to vary rates, or can push wage rates down, then they may have little option but to do this* (Harding, 1991).

Another has noted:

> *Given an independent budget, and freedom to pay as they wish, many managers may display a damaging meanness in pay awards* (Vinograd, 1991).

In general, rather than focusing directly on pay

levels, managers were looking to skill mix alterations and skill substitution as the main source of costs savings, in the short term. There was a recognition that this focus on more effective deployment of staff, and on altering the mix of staff employed (usually by reducing the number of comparatively 'expensive' trained staff) was likely to prove a less problematical source of immediate cost savings than would a concentration of effort directly on the paybill. One trust director of personnel commented, 'We won't flog the pay issue – much more money can be pulled out of skill mix changes'. Another manager – at a potential 'second wave' trust – noted, 'We will fund our performance related pay scheme by altering skill mix and by job cuts'.

This focus on skill mix and deployment highlights the importance of examining payment systems in a broader context which includes other employment and deployment issues. The overall size of the paybill can be controlled directly, by negotiating or unilaterally imposing a specific level of pay, but it can also be controlled indirectly (but just as effectively) by limiting or reducing the number of staff receiving any specific level of pay.

This managerial perspective gives a lower priority to quality and level of care issues in skill mix than do some other commentators (see Buchan and Ball, 1991; Audit Commission 1991, Carr-Hill et al., 1992). Some managers appear to have concluded that paybill control is best achieved by employing comparatively fewer 'expensive' trained nurses, and comparatively more 'cheaper' healthcare assistants and other support workers. The scope for change has been quantified by one manager (Rogers, 1991) who suggested that the qualified: unqualified staff ratio in nursing could be altered from 70:30 to 45:55 over the next decade.

Industrial relations

Most management respondents regarded the current system of industrial relations in the NHS as unwieldy and over reliant on centrally determined procedures and agreements. Those planning radical changes in nurses pay determination were doing so within the broader context of restructuring the industrial relations system for all groups of staff. Main stated objectives of these respondents was to reduce the number of recognised trade unions, to simplify local procedures, and to limit the bargaining rights of unions. Some managers stated that their long term aim was to end collective representation of the workforce and to deal with employees on an individual basis. One of them stated, 'We will recognise those unions with a significant membership, but will move away from collective bargaining – ultimately our approach will be individual'.

One approach being used by a number of trusts to effect a reduction in the number of unions was to establish 'single table' bargaining with a limited number of union 'seats' (eg six). The unions were then being left to decide amongst themselves which would occupy the seats. Other managers were planning to implement a functional split in industrial relations, with only one union being recognised for each employee group (medical, nursing, administrative etc).

From a union perspective, there are both threats and opportunities in these developments. Some of the smaller professional unions (eg Royal College of Midwives, Health Visitors Association) may be in danger of being marginalised in some trusts, where they may lose bargaining rights and influence to the large unions. The current merger of NUPE, NALGO and COHSE would create an organisation with the potential of representing all groups of workers with an employing unit, and raises the possibility of 'single union' deals being struck. However, none of the management respondents regarded this as a likely or desirable option, believing it would lend too much bargaining power to one organisation. Whilst decrying the inefficiencies of the current multi-union system, most were wary of replacing it with a single union deal.

Discussions with trade union representatives revealed them to be both optimistic and pragmatic about their future role. Their optimism is based on a number of factors: the likelihood of a 'tight' labour market (becoming less apparent in the 1991-92 recession) ; their belief that management cannot deliver change without the cooperation of union members; their assessment that management in many units will not have the skills or resources to bargain effectively at a local level; and (for some at least) the unfulfilled wish that trusts were just a temporary problem, which would disappear in the aftermath of a Labour victory at the next general election.

Their pragmatism revealed itself in a flexible, almost opportunistic view of the future shape of industrial relations. Single union deals and no strike deals were not ruled out by some interviewees, and all indicated that they thought local level bargaining would provide opportunities for 'leapfrogging' pay deals. Differences in pay and conditions offered by competing hospitals could, they believed, be examined and exploited by local union representatives.

Union interviewees regarded national level bargaining as the most 'sensible' way of negotiating nurses pay, but were keen to emphasise their perceived strengths if negotiations were to be conducted locally. This optimistic public face may however hide private concerns about potential weaknesses at local level, in some units. These weaknesses could include the varying capabilities of local level representatives to conduct detailed negotiations, the effect of increased

workload on full time officials, and the actual union membership density in some units being revealed to be very low.

One opportunity for unions, which may be underestimated by some management, is the possibility that new salary structures or pay determination mechanisms (eg job evaluation or PRP) could be claimed by unions to be discriminatory against women, or to undermine equal value legislation. Legal casework in this area is limited, but the greater the variation in new systems, the more likely it is that a union may 'test' a system it regards as unsound. This could become most apparent in employing units which attempt to assimilate all groups of employees onto a common 'pay spine'.

The greater the devolution of pay determination, and given fluctuations in union membership and influence at local level, the greater is the likelihood that the ability of unions to have a significant influence on pay determination will be severely constrained in some geographical areas. Inter-union rivalry could occur where 'beauty contests' are run by management wishing to recognise only a limited number of unions, and the end result would be a much more variable employee relations climate than currently exists in nursing in the NHS. The traditional 'non-militant' stance of many nurses could be more severely tested than under the current system, where the Review Body (established by the government as a 'reward' to non striking nurses) has taken much of the 'heat' out of the employee relations climate.

In general, managers in the majority of units (where planned changes in the system of nurse pay determination were less radical than in some of the trusts) did not regard union 'power' at a local level to be a major obstacle to change. These managers tended to have a pluralist and pragmatic view of industrial relations, and regarded some of their more macho brethren as being short sighted if they believed that more rapid change could be achieved without the cooperation of the unions and their members. This pragmatism may have owed much to the pre-reform 'culture' in the NHS, but also stemmed at least partly from a recognition that the limited resources available to them as personnel practitioners often prevented the 'delivery' of more rapid and fundamental changes in the system of industrial relations.

The personnel function

The devolution to unit level of many aspects of the personnel function is a central theme of the NHS White Paper.

> *For some time the Government has been concentrating on giving more responsibility for taking decisions to those actually working hospitals. The White Paper aims to take this process further by progressively introducing greater pay flexibility throughout the service to allow managers to relate pay to local labour markets and to reward individual performance* (p.6, Working for Patients. A Summary, HMSO).

Many personnel managers at Unit level were concerned that their function was inadequately prepared and under-resourced in three important areas – human resource planning (including labour market analysis and workforce profiling), remuneration planning (including job evaluation), and negotiating skills. These three elements are integral to any successful local level pay determination process, and it was apparent from the response of some interviewees that they believed the move towards local pay determination would founder, unless more resources were made available to staff the personnel function at unit level.

Four responses to these perceived inadequacies could be identified, three at trust/unit level, and one at Regional Health Authority level. At trust/unit level, appropriate expertise was being developed by training personnel staff in negotiating skills, labour market analysis, etc. and was being 'bought in' either permanently, by recruiting new staff with skills often developed in the private sector, or temporarily, by employing management consultants to contribute to the development of local level pay strategy. These developments were most evident in the first wave trusts, but were widely occurring elsewhere.

At Regional level, a number of Regional Health Authorities (eg North West Thames) had established or were establishing specialist pay/labour market units, providing research, consultancy and training to staff in directly managed units and trusts. Some of the more independently minded trusts are apparently suspicious of this development, regarding it as a continuation of Regional control and 'interference' under a different name. Some appear unwilling to participate in Regional initiatives or the exchange of pay and labour market information because they regard such data as commercially sensitive.

There was general agreement from respondents that the current resources available to the personnel function in many trusts and units could act as a significant constraint to developments in pay determination. Devolution of pay bargaining to local level could not be adequately implemented and sustained without developing more skills and expertise in labour market skills, remuneration strategy and negotiation. This was not primarily a reflection of any 'inadequacies' of current staff in the personnel function, but rather an indication that the demands made of that function were perceived to be rapidly changing. In recognition of these shortcomings, the

Personnel Development Unit (PDU) at the National Health Service Management Executive promoted training seminars on pay issues for personnel staff in trusts.

Labour markets

In general, few respondents identified any labour market factors which they felt would significantly constrain their plans for changes in the system of nurses pay determination. As noted earlier, most reports of recruitment difficulties were related to specific specialties or grades of nursing staff rather than to general problems.

Respondents indicated that this was partly a result of general economic recession, and some expressed concern about future labour supply, if the economy entered an upturn, and the predicted demographic decline in new recruits became more prominent. These concerns were largely expressed in generalities, and were usually not the result of a detailed assessment of future local demand and supply. Similarly, some respondents indicated that future skill mix changes might reduce the requirement for qualified nursing staff, but could not quantify this reduction.

In essence, many management respondents lacked a detailed vision of where and how their own units' requirements for nursing staff fitted in the 'big picture' of local and national labour markets. This lack of vision is perhaps unsurprising, as labour market analysis was not a management priority in a centralised system, but decentralisation has exposed a lack of clarity and detail in some units and trusts.

Whilst these shortcomings are being addressed by training current staff and by recruiting new blood to the personnel function it remains the case that at the time of the case studies, management in some units and trusts had only a hazy notion of the dynamics of the labour markets relevant to their human resourcing requirements. This was due as much to inadequacies in the available labour market data as to an absence of available skills in the personnel function. The Review Body, in its 1992 report, expressed concern at the 'lack of relevant and reliable manpower data' (para 43).

In questioning management respondents on their future pay determination plans, many had expressed a desire to establish systems which more accurately reflected local labour market conditions. Given the complex labour market dynamics evident in the nursing workforce and the varying capabilities of local management to conduct labour market analysis, it is unlikely that this will be achieved in the short term in some units.

The fact that most management interviewees did not perceive significant labour market constraints on their future pay plans has therefore to be tempered with the knowledge that their labour market perceptions were often based on general considerations rather than on a detailed assessment and analysis of the characteristics of the labour markets in which they operated.

6

CONSTRAINTS ON CHANGE IN NURSES PAY DETERMINATION

Funding

- **options for change limited by availability of funding;**
- **new developments will have to be 'self financed' from contracts – pressure for cost containment;**
- **initial focus on reducing costs by altering staffing levels and mix, rather than by addressing pay issues;**

Industrial Relations

- **many managers wish to reduce number of recognised unions; few regard single union deals as likely to occur;**
- **unions expressing confidence in their capabilities to exploit local bargaining; management not overly concerned about union power;**

Staffing the Personnel Function

- **many units require enhanced capabilities in human resource planning, pay research and negotiating skills if they are to manage change;**

Labour Market Conditions

- **absence of detailed knowledge of local labour markets makes assessment of labour market effect difficult;**
- **little concern about general recruitment problems.**

Source: **23 Case Study Sites**

The various constraints to changes in nurses pay determination are listed in Box 6. The major constraints identified by management respondents related to funding limitations, and to current shortcomings in the capabilities of the personnel function in some trusts and units. Industrial relations and labour market constraints were not ascribed the same priority by most of the managers interviewed in the case studies.

Trade union interviewees, whilst continuing to argue for national bargaining, appeared to face the possibility of local level determination with equanimity.

Factors in future pay determination

Management respondents in case studies were asked to indicate which of eleven listed factors they regarded as very important in determining nurses pay. Responses from managers in trusts and

Table 4 Factors regarded as very important in determining nurses' pay

Factor	Trusts	DMUs
	%	%
cost of living	62	60
pay of nurses in other local units	50	40
pay of nurses nationally	–	47
pay of other health employees	–	-
strength of unions/threat of industrial action	–	-
productivity	100	60
ability to pay	100	93
economic climate	38	33
the going rate	–	20
recruitment difficulties	62	47
performance related/ merit pay	50	33
N=	8	15

Source: Case Study Sites

directly managed units is shown in Table 4. As can be seen, the pattern of responses from the two sub groups varies. 'Ability to pay' is the most often reported factor in both sub groups, but respondents in trusts were more likely to focus on a narrower range of factors, linked primarily to business objectives and local labour markets. National pay rates, relativities with other groups of NHS workers and broader notions of the 'going rate' were not cited as major factors by any respondent in a trust.

The main difference in response from the two groups was in relation to productivity. All trust respondents regarded productivity to be an important factor in pay determination, in comparison to two-thirds of DMU respondents. In contrast, no respondent in either group cited 'strength of unions/threat of industrial action' to be a factor of importance.

Responses to the issue of 'pay of nurses in other local units' revealed that some respondents were considering how best to coordinate their pay determination activities with other local units. This was most apparent in trusts located in large conurbations, but some managers in DMUs were also beginning to review the situation. One manager from a trust sharing labour markets with other trusts stated, 'I'd speculate that there would be some form of understanding – cartel may be too strong a word for it'. Another, in a similar situation, noted 'we're establishing links with other units in the labour market to share ideas on pay – we're a little nervous about what we should talk about, but it will probably remain informal'. Two others, in DMUs indicated they believed informal cartels would be formed with other employing units, to establish parameters for nurse pay levels.

One NHS Regional Director of Personnel was recently cited as envisaging, 'the possibility of area salary agreements between competing providers to prevent spiralling wage claims' (Lyall, 1991). Another NHS manager has written that, 'some informal mechanisms for sharing what is going a on in the area of pay and bargaining will be important' (Fillingham, 1991). In a labour market where several employers are competing for nurses, such collaboration makes financial sense from a managerial perspective, but is likely to exert a downward pressure on pay levels of individual nurses in the labour market. Research in the US on nurses pay (Friss, 1987) suggests there will be little need for a formal cartel, providing employers share pay information and communicate informally.

A comparatively small sample of trusts and units were studied, and caution must be exercised in generalising from the results. However, there is evidence to suggest that trusts are beginning to establish a narrower, more 'business' orientated approach to pay determination. It is also apparent that some form of coordinated pay determination between employing units is being considered in some labour markets. These activities may not be as formal as a cartel but could have a similar impact in limiting pay variations.

'Winners and Losers'

In order to obtain some indication of which grades or specialties of nursing staff were likely to benefit from any planned changes in the system of nurse's pay determination, management respondents were asked if they could identify any likely comparative nurse 'winners' or 'losers' in a changed structure. Box 7 shows the main specialties reported by case study managers.

Some respondents did not wish to identify specific groups as likely winners or losers, one trust director of personnel suggesting that 'all will be winners' under a new system. The responses from other managers reveals that the potential 'winners' tended to be in specialties currently regarded as having a national shortage of trained staff – the 'high tech' areas, theatres, intensive care and special care baby units – or were groups who, it is perceived, will take on more responsibilities in a revised staffing structure. In particular, ward sisters or ward managers with enhanced budgetary responsibilities were regarded as a group who would be paid comparatively highly under a new system.

Grades and specialties whom some

7

'WINNERS AND LOSERS'

Grades/Specialties thought likely to do comparably better or worse under revised pay structure.

'Winners'	(N)
Ward sister/ward manager	(5)
'High Tech'	(3)
Intensive care	(3)
Special care baby unit	(2)
Theatre	(2)
Community	(2)
Auxiliaries (some)	(1)
'Losers'	
Nurse managers	(2)
Auxiliaries	(2)
Outpatients	(2)
Night nurses	(1)
Geriatric	(1)
Community	(1)
D grades	(1)
Enrolled nurses	(1)

Source: Case Study Sites

management respondents thought would lose out under a revised pay structure were nurse managers (two respondents indicated they thought nurse managers were overpaid in comparison to other NHS managers with similar responsibilities), nurses working in outpatients (the subject of a recent, critical report form the NHS Management Executive [NHSME,1990]), nurses working on night shift and in the geriatric specialties, and nursing auxiliaries.

These responses can only be regarded as indicative of possible trends, but is evident that comparative 'winners', in terms of grade or specialty, are likely to be those nurses who have skills regarded by management to be in short supply, or whose role is perceived to contribute significantly to the business success of the trust of unit. If greater 'individualisation' of pay becomes a reality, it is likely that nurses working in the less glamorous (and often financially less lucrative in business terms) 'cinderella' specialties who may be comparative losers, in pay terms, along with some grades of nurse manager (many of whom are, in any case, being transferred onto general management pay scales), and nursing auxiliaries.

Paying the Health Care Assistant/Support Worker

The development of the new role of health care assistant (HCA) has arisen out of the need to plug the staffing 'gap' left when student nurses become supernumary under the revised 'Project 2000' system of nurse education. At the time of the case studies, several units had begun training and employing healthcare assistants and other support workers, and most were considering what terms and conditions of employment to offer. HCAs have taken on a greater significance for managers than merely acting as replacements for supernumary nurse learners. The establishment of the HCA grade has given management the stimulus to undertake a broader review of current employment practices and grade mix in nursing.

As noted in the previous chapter, the salary differential between qualified and unqualified nursing staff has increased in recent years. It could be argued that three of the 'successes' of the nursing profession in the 1980s – the establishment of the Review Body (which has presided over these increasing differentials), the introduction of clinical grading (which focussed management attention on what nurses actually do) and the implementation of Project 2000 (which led to the nursing profession agreeing that HCAs could be employed) have created a climate in which skill substitution of nurses by 'cheaper' HCAs has risen in NHS managements' list of priorities.

As a matter of policy, the NHSME had stressed that HCA pay and conditions are to be determined by individual employing units – the first group of NHS workers to have their terms and conditions determined solely at local level. The work of HCAs and qualified nurses will overlap, and it is therefore of relevance to identify how case study sites were planning to remunerate HCAs. Were they going to 'slot' them into the nursing pay grades, or were they going to establish a separate pay structure?

The response from twenty case studies is listed in Box 8. Devolution of responsibility for determining the pay of HCAs appears to have created a diversity of thoughts and opinions, with the views of some respondents apparently contradicting that of others. Two general perspectives can be identified, with minor variations being reported from each case study site.

One school of thought believes that HCAs should be paid on, or directly linked with, the nursing clinical grades (usually A and B, sometimes also C, D or E) in order to maintain differentials and facilitate career progression of HCAs. The other body of opinion stresses the opposite view – that HCAs should have a separate pay system, in order to emphasise that they are different from nurses, and that they are generic healthcare workers who can be flexibly deployed across a variety of work settings.

8

TWENTY WAYS TO PAY AN HCA

THOUGHTS FROM 20 CASE STUDY SITES

1	Clinical grade B+-	'we'd prefer not to lock into nursing grades'
2	on N&M scales	'to put them on Admin & Clerical scales would be crazy, assuming the Review Body continues'
3	link to Admin & Clerical	with grades related to NVQ levels
4	own system	from below clinical grade A, to above grade B
5	own system	from below clinical grade A, to above grade C
6	linked to auxiliary pay rates	
7	link to Admin & Clerical	'HCAs will do any task that nurses currently do other than those protected by statute'
8	link to Nursing & Midwifery grades A-C	'A potential recipe for disaster if we negotiate separately'
9	own system	based on percentage of clinical nurse grade D, (no increments)
10	Link to nursing grade B, perhaps C	
11	own pay spine linked to nursing grades A-E	'I can see the day when HCAs do the work of D&E grade nurses'
12	clinical grade A+	'we'll only pay them when they're here (no holiday or sick pay)
13	own pay spine	'we'll need to watch equal value link with auxiliaries'
14	own 12 point pay spine, linked to clinical grades	
15	clinical grades A&B	'tied in for career progression'
16	own system	'they will be generic, non Whitley, non Review Body'
17	own system	'we will be able to pay HCAs less than a qualified nurse, but they will be doing largely the same role'
18	own system	five grades
19	Clinical grades A-C	
20	own system	

Source: Case Study Sites

Some respondents in each camp viewed HCAs as ready-made (and cheaper) substitutes for qualified nurses. Plans to 'reprofile' the healthcare workforce, and to review skill mix, were raising the issue of skill substitution as a means of cost containment, and in this respect, the development of the role of HCA was concentrating the minds of many management respondents on the cost saving potential of a HCA/qualified nurse overlap. One unit was reported to be planning to abolish grades A and B (and perhaps C) of the clinical grading structure, and moving nursing staff on those grades to a separate structure (Industrial Relations Services, 1990).

Trusts and units may not be 'greenfield sites', and may not offer the potential of a fresh start in industrial relations, but to management the HCA can represent the next best thing – a 'new' worker untainted by Whitleyism and unfettered by national pay and conditions. As such, it is important to view developments in nurses pay determination in relation to unit plans for HCA remuneration. The two are inextricably linked, because the work roles of nurses and HCAs will overlap.

This overlap, and the potential for substituting nurses with 'cheaper' HCAs may leave individual employers open to union sponsored 'equal value' claims, where job content of different workers is determined to be similar, but pay levels are different (Buchan, 1991).

Overview

Detailed responses from management in the 23 case study sites has revealed that the majority considered it important to retain an element of national pay determination, to set a 'baseline' or parameters to which they could flexibly respond, by adjusting pay locally in response to business priorities and labour market conditions. A minority of responses in trusts envisaged a more radical departure from the current system, where a 'stand alone' structure was being planned.

In terms of scrutinising labour costs, most management respondents regarded skill mix and skill substitution as the first priority. 'Reprofiling' the workforce was viewed as a potential source of cost saving which could be achieved more rapidly, and with less labour relations problems, than would a direct focus on the paybill.

In relation to changing the nature of nurses' pay determination, the main direction of change was towards some 'individualisation' of pay – either through implementing some form of performance related pay, or through establishing 'new' non-Whitley posts. However, most respondents believed these developments would occur within a framework retaining elements of national pay determination. At the time of the case studies, there was little evidence of radical changes having occurred – most trusts and DMU's were still at an early stage of planning.

Constraints on the pace of change were regarded as significant, and primarily resource linked – in relation to funding availability and the existence of sufficient expertise in the personnel function. 'External' factors, related to labour market pressures and the strength of unions and professional organisations, were accorded only secondary importance.

Most respondents indicated that they believed pay relativities between different groups of nurses would alter. Comparative 'winners' identified by these managers were in the skilled 'shortage' specialties (eg theatre nurses) and in ward sister/ward manager posts.

The remuneration of health care assistants was an issue exercising minds in most of the case study units. Responses suggest a broad range of possible payment systems were being considered, some linked to the nursing grades, others (deliberately) kept separate. This apparent contradiction reflects differing management philosophies, at unit level, regarding the status and career development potential of the HCA grade.

In overall terms, it is apparent that the NHSME has achieved some success in changing local management culture towards a more business orientated approach. What is less clear is how this change in managerial culture will or could be translated into the day to day realities of managing the personnel function. In some units, in pay determination terms, there is an apparent gap between the central impetus for local change, and the local level capabilities to deliver and manage that change. In particular, the labour market effects of changing payment systems have not always been fully appreciated. In the next chapter, detailed consideration will be given to these labour market factors.

4 The labour market context

Whilst we do not believe that, whatever the level of pay, men and women would enter the profession solely for the monetary rewards provided, we regard it as essential that the vocational nature of the job should not lead to undervaluation of it in financial terms. We believe that this has happened in the past, for a variety of reasons, one of which is that it is predominantly a woman's profession (Halsbury (1974) para 60).

Trends in pay data and plans for changes in pay determination are only meaningful if examined in relation to other labour market indicators. This chapter considers the labour market characteristics of nurses, competing demand for nurses, and the role of pay in nursing labour markets. To what extent were the plans for pay devolution, outlined in the previous chapter, of relevance to the dynamics of the nursing labour market?

9

KEY PUBLISHED SOURCES OF LABOUR MARKET DATA ON NURSES

- **The national survey of nurses in the NHS, in non NHS nursing and not employed (Price Waterhouse, 1987).**
- **The series of national surveys of members of the Royal College of Nursing conducted by the Institute of Manpower Studies, 1986–91 (Waite and Hutt, 1987; Waite, Buchan and Thomas, 1989; Buchan, Waite and Thomas, 1989; Buchan and Seccombe 1991).**
- **The national survey of nurses on the Scottish Register (Waite, Buchan and Thomas, 1990).**
- **The national survey of members of the Royal College of Midwives (Buchan and Stock, 1990).**
- ***'NHS Workforce in England'*, the annual compendium of staffing statistics, published by the Department of Health (DoH, 1991).**
- **The annual Review Body reports, which give details of staffing levels, vacancies and pay rates.**
- **Annual reports of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting, which gives details of number of nurses on the register and numbers in training.**

10

KEY LABOUR MARKET CHARACTERISTICS OF NHS NURSES

- **+90% are female**
- **35% of qualified staff work part time**
- **58% of unqualified staff work part time**
- **One third of qualified staff is aged less than 30, over half are aged 30–49.**
- **One quarter of unqualified staff are aged 50+**
- **Turnover of qualified staff (ie job moves within the NHS) is high; wastage (ie moves to jobs outside nursing)is low – most 'leavers' are going on career break or maternity leave**
- **Geographical mobility of many qualified staff – particularly those with domestic responsibilities – is restricted**
- **Approximately half of the qualified nursing labour force (ie all those on the UKCC register) are working in the NHS. Most of the remainder are not making use of their nursing qualifications in paid employment**

Labour market characteristics of nurses

The labour market characteristics of qualified nurses and midwives received considerable research-based attention in the 1980s mainly as a result of concern about recruitment and retention difficulties. Key national sources are listed in Box 9, and the key labour market characteristics of the NHS nursing workforce are identified in Box 10. The nursing workforce is mainly female and exhibits a high level of job mobility (but much less geographical mobility).

There is no single national labour market for nurses, but rather a series of interlinked and overlapping geographical and skill based labour markets of varying sizes and dimensions. The age, gender, marital status, career history, basic and post basic qualifications and employment status (full or part time) of each individual nurse all play a part in determining in which labour market she or he is located. This labour market system is dynamic, as the labour market characteristics of individual nurses may change over time, and their

labour market behaviour may alter. For example, a young, single nurse working full time, and with post basic specialist qualifications is likely to occupy a larger labour market (in geographical terms) than does an older nurse with domestic commitments, who works part time. Rather than dictating a single, readily defined labour market, the varied characteristics of individual nurses act to create a more fluid situation, with a series of interlinked labour markets of differing dimensions, with significant flows of nurses between these markets, as well as to and from the profession itself.

Competing demand for nurses

There are over 600,000 qualified nurses and midwives registered with the United Kingdom Central Council for Nursing, Midwifery and Health Visiting, the registration body for the professions. This is the 'pool' from which the NHS, and other employers must recruit qualified staff.

Approximately 53 per cent of the total pool of nurses are employed in the NHS. A detailed picture of the disposition of qualified nurses in other forms of employment is difficult to establish. In England, in the late 1980s it can be estimated that at least 68,000 qualified staff were employed in non-NHS employment, mainly in private sector nursing homes. Box 11 gives details of the approximate numbers of nurses in non-NHS employment. In overall terms, approximately four times as many qualified nurses work in the NHS than in all other forms of employment combined. However, it should be noted that GP practices and nursing homes are growing rapidly in importance as sources of employment of nursing staff. DoH data suggests the number of qualified nursing staff working in the independent sector has doubled in the 1980s, and the number of practice nurses has tripled, whilst NHS employment has remained static since the mid-1980s.

The dominance of the NHS is further emphasised when it is noted that all but 95 of the 19,688 training places for first level of the training are NHS based (Department of Health, 1991). The NHS is both the major educator and employer of nurses.

The 'monopsony effect' of the NHS has important implications for labour market behaviour and for nurses' pay. As the dominant employer, NHS pay rates have dictated what the 'market rate' for nurses pay will be, rather than the 'market' dictating what NHS nurses pay should be. The move from a single national NHS rate to local variations in NHS pay rates may complicate this situation. However, in economic terms, at both national and local level, the NHS is likely to continue to exert near monopsonistic power in purchasing the services of qualified nurses – that is, it will nearly always be the major employer, and often will be the only employer of nurses in a specific labour market.

11

QUALIFIED NURSES IN NON-NHS EMPLOYMENT

(ESTIMATES: ENGLAND)

		No.
1	INDEPENDENT ACUTE HOSPITALS, NURSING HOMES, SCREENING SERVICES	
	Registered Nurses	31,973
	Enrolled Nurses	13,607
	Midwives	241
	Other	2,415
	Total	48,196
2	PRACTICE NURSING	13,280
3	OCCUPATIONAL HEALTH	8,000
	APPROX TOTAL	68,000

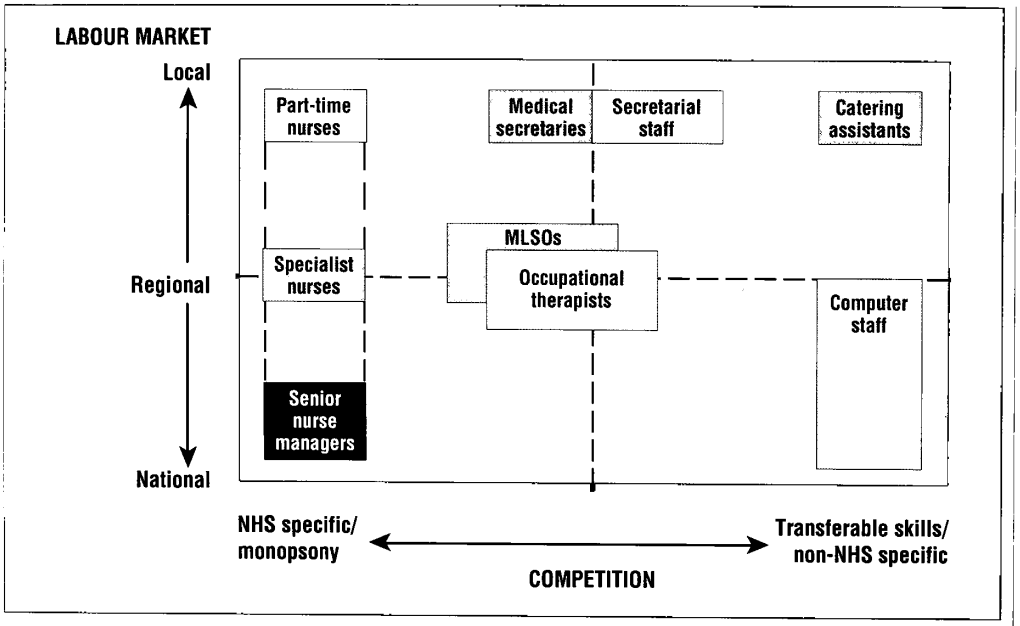
Sources: **1 and 2 – Department of Health, England 1990, 3 – RCN estimate.**

(Note: Excludes Armed Forces)

The implementation of the NHS Act in April 1991 has created a situation in which there are several hundred directly managed units (DMUs) and Trusts, each acting as an employer. In many labour markets, the major competition for nurses will be between NHS units, rather than with other, non-NHS employers. In particular, in larger conurbations and metropolitan areas, several DMUs and trusts may be competitors in recruiting and retaining nurses.

The current labour market situation of nurses in relation to other NHS employees is graphically illustrated in Figure 6. Nurses do not occupy a single local, regional or national geographic labour market, but are distributed across many. In terms of NHS occupational labour markets the nursing occupation is located at the 'limited competition' monopsony end of the continuum – in general the NHS represents the main source of employment. Many nurses are also recruited from within a local labour market. In terms of pay determination it can be argued that the need for pay flexibility in order to compete in the labour market becomes less pronounced the more an organisation is in the 'limited competition' and 'local labour market' quadrants of the matrix.

Figure 6 Framework for categorising NHS labour markets



Sources: Buchan, 1989; Meager *et al.* 1990.

The role of pay

Despite its perceived importance as a mechanism for recruiting, retaining and motivating staff, the precise role of pay in determining or influencing employee behaviour has rarely been examined in isolation from other factors, in nursing or any other occupation. There is no generally accepted model of the relationship between pay and recruitment, turnover or performance.

In nursing, much of the recurring concern about shortages of nursing staff, in Britain and elsewhere, has focused on pay – either low pay as a causal factor, or improved pay as a solution. It has been argued that comparatively low pay rates in nursing have acted as a disincentive to enter the profession, have caused high turnover rates, and are related to low morale and demotivation of staff.

Whilst this argument is superficially persuasive, it has to be viewed within the context of the labour market characteristics and behaviour of nurses, and the monopsony effect of the NHS. Comparatively little research has attempted to address this complex issue.

Nurses pay and labour market characteristics:

UK research

Research on the relationship between pay and labour market characteristics of nurses in Britain can only be regarded as exploratory. Hoskins (1981a and 1981b) used regression analysis to establish tentative links between the supply of nursing and midwifery staff and pay rates. He claimed that 'the rate at which midwives leave their work, and hence the total stock of midwives is sensitive to pay changes' (Hoskins, ref, p.37).

More recently, Gray *et al.* (1988) researched the links between nurse turnover and a number of local labour market variables (eg unemployment rates). Using regression analysis they identified how much of the variation in nurse turnover could be explained by local labour market conditions. They found a significant relationship between turnover rates and three variables – local unemployment, size of the private nursing home sector, and level of non-manual female earnings. (Hoskins had not found a link with unemployment, other than for part time staff.)

US research

The relationship between nurses pay and labour market characteristics has received more research-based attention in the United States than in Britain. The effect of unionisation on nurses pay, the links between monopsony power and pay levels, and the relationship between pay rates and participation rates have all been the subject of research attention in the US. In terms of age profile, participation rates, a high incidence of part time work, and a high proportion of females, the characteristics of the US nursing workforce are similar to that in Britain. The restricted

geographical mobility of many nurses, and the existence of many interlinked regional labour markets, rather than one national labour market, are other characteristics common to both countries (Cleland, 1990). However, the US differs from Britain in two important aspects of nurses pay determination. First, there has never been coordinated national pay determination in the US. Nurses pay has normally been set at hospital level. Second, the level of unionisation of nurses has been lower in the US, and has varied markedly between different hospitals, states and regions. The existence and coverage of collective bargaining has also been less widespread in the US; many nurses have their pay determined unilaterally by their employer.

Some US researchers have found evidence which suggests that the existence of collective bargaining is linked to higher pay rates for nurses. Becker, Sloan and Steinwald (1982) conducted large scale research which suggested that the 'union' effect for RNs (Registered Nurses) was to increase wages by 6 per cent in comparison to non-unionised nurses. The same study found evidence of higher pay increases in hospitals which had experienced work stoppages. More recent research (see Brider, 1991) suggest the 'union effect' adds 5–7 per cent to salary.

Earlier research (Miller, Becker and Krinsky, 1979) had found that where multiple bargaining units existed (ie where employers formed an association), lower salary costs ensued than in single bargaining units:

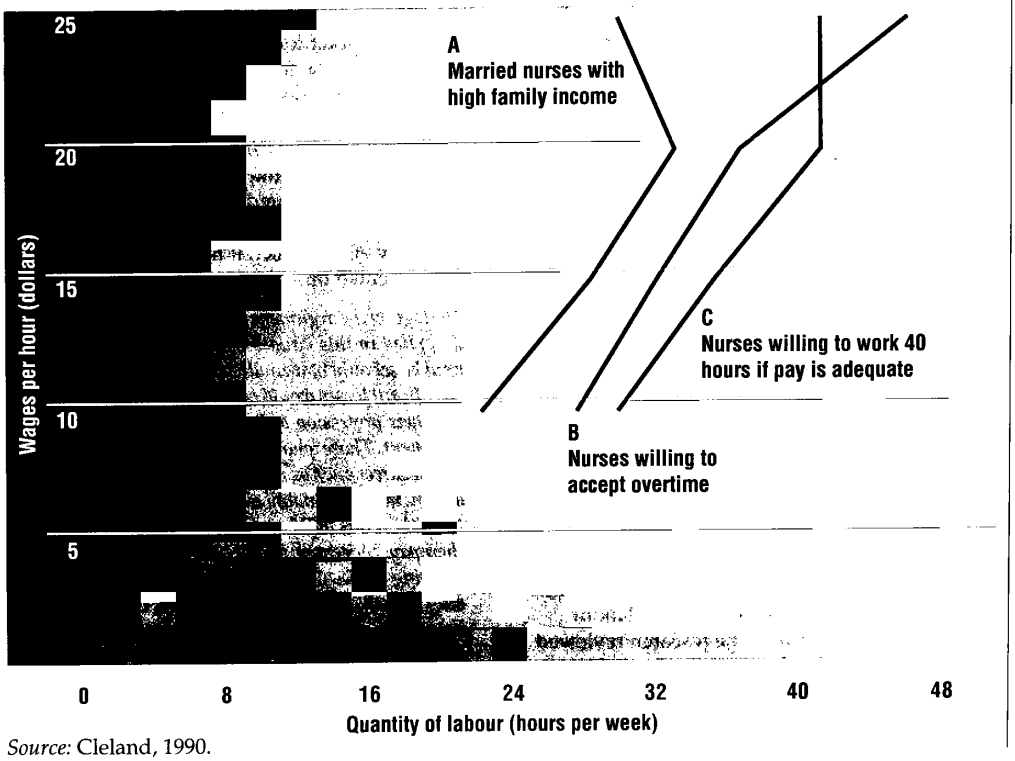
> *This bargaining structure tends to reduce much of the internal whipsawing that might prevail in single employer bargaining, and apparently provides sufficient countervailing power to minimise union gains* (p.101).

The same argument, from a different perspective, was promoted by Cleland (1990). She argued that unionisation of nurses acted as a countervailing force to monopsony based employer wage-setting cartels.

Results of the various US studies on monopsony power and on participation rates are neither conclusive nor mutually supportive. The majority of studies examining monopsony power have found evidence of its existence, and most studies looking at participation rates have revealed a direct relationship with pay levels, but some studies have found no indication of such a correlation.

Some research (eg Link and Settle, 1981) has even claimed evidence of a 'backward bending supply curve' for married nurses, arguing that

Figure 7 Segments of staff nurse labour supply curves (USA).



Source: Cleland, 1990.

when their pay rates are increased they reduce the hours they work. If this scenario is to be believed, pay increases for some groups of nurses may act to reduce the net number of hours they work (see also Cleland, 1990). Figure 7 illustrates the implications of the 'backward bending supply curve'. It is argued that group A will substitute greater leisure time when wages per hour are increased.

The effect of monopsony in suppressing nurse pay rates in the United States was cited as a major factor in creating the nursing shortages evident in the 1960s and 1970s. One researcher (Yett, 1970) conducted a survey of the 31 largest hospital associations in the United States to determine whether or not they ran 'wage stabilisation' programmes. Fourteen of the 15 hospital associations which responded to his survey indicated that they did cooperate in some form of wage setting, whilst the fifteenth asked for advice on how to establish a wage stabilisation programme. More recent examples of employer collusion to maintain nurse pay rates in the United States have been reported by Friss (1987) and Cleland (1990), and other researchers (eg Link and Landon, 1975; and, Booton and Lane, 1985) have claimed to find evidence of a monopsony effect on nurse pay levels.

The US research, although fragmentary, has lent support to the theory that there is a monopsony effect at work in many nursing labour markets. It has been argued that in a labour market where there is only one significant employer of nurses (monopsony) or where there is a small number of employers (oligopsony), the comparative lack of competition limits the effect of market adjustments on pay levels. The 'free market' may exist, but there is only one buyer, who can set the 'going rate', or a small group of buyers, who may collude to maintain pay levels at a level below that which would be dictated by the 'market'.

Overview

Pay levels in nursing are often regarded as the main reason for labour market problems (because pay is 'low') or are promoted as the main solution to labour market problems (because pay can be increased). This assumption that there is a direct linear relationship between pay rates and labour market behaviour – that adjusting pay will have a predictable effect on labour market behaviour of nurses – oversimplifies a much more complex issue. Pay is only one of a number of factors which may play a role in shaping or dictating labour market behaviour. Some of the research reviewed in the previous section has tentatively confirmed links between pay rates and other factors, such as participation rates and turnover, but the relationship, if positive, has often been found to be weak. In this respect it has to be acknowledged that nursing does not differ from most other occupational labour markets – there is no commonly accepted and proven model of the role and impact of pay on labour market behaviour.

The effect of monopsony, the limited geographical mobility of many nurses, and the requirement made of many nurses to achieve a balance between career and domestic commitments ensure that the relationship between nurses pay and labour market behaviour is a complex one. In essence, adjusting nurses pay with an expectation of achieving a desired change in labour market behaviour requires an element of faith, as well as a sufficiency of funding. As the Review Body noted in 1986:

> *The contribution of pay levels to the ease or difficulty of recruitment is open to dispute. We accept that many factors may contribute to staff shortages in particular areas of work but we do not believe that pay levels play no part at all ... it cannot be assumed that the level of pay has nothing to do with the lack of suitable applicants. Conversely, we do not accept that the ability to recruit and retain enough staff is conclusive evidence that current levels of pay are fair. Other factors, for example the absence of alternative employment, have to be taken into account* (para. 49).

Research from the United States, where pay determination is localised, suggests that employers of nurses often pay below the level which would be dictated by market forces, because there is often limited competition for nursing staff in a labour market, and collusion exists between employers to maintain pay levels. US evidence also suggests that this monopsony effect can be less evident where nurses are unionised and bargain collectively.

In the United Kingdom, it can be argued that the Review Body has provided a check against the monopsony effect, which it has itself recognised and commented on.

> *The logic of the argument about market forces would, if applied to this situation, suggest that pay levels need be set only marginally above the point at which significant losses would occur from nurses abandoning their profession and seeking other forms of employment. Those who commit themselves to a professional career such as nursing, and eschew industrial action, may reasonably expect that wider considerations than this will be taken into account in settling their pay. Moreover, the NHS controls the number of training places and therefore the supply of trained staff as well as the demand for them; in such a near-monopoly situation, the sufficiency of applicants at any time is an inconclusive test of the adequacy of existing pay levels* (1991, para.30).

Given the labour market characteristics of nurses these comments can apply equally in a nationally

or locally determined payment system. Devolving pay determination will not, in itself alter the labour market characteristics of the nursing workforce, and may only marginally affect labour market behaviour. Removing the Review Body, and its countervailing effect on monopsony, could increase the impact of monopsony at local level, particularly where there is formal or informal collaboration between employers. The final chapter will examine in greater detail possible labour market implications of devolving pay determination, and will also consider if the Review Body could be retained under a system of local pay determination.

5 'Flexibility or fragmentation?'

There have been many changes in management arrangements and structure over the years, but the reforms now under way, and particularly the personnel freedoms given to NHS Trusts, offer the most significant opportunity for a quantum leap forward in human resource management than at any time in our history Peter Johnson Deputy Director, NHSME, September 1991.

We do not propose to comment on our future role. It is for the government to decide our terms of reference and for the parties to bring evidence to us in the light of those terms of reference (Review Body, 1992 para.35).

This chapter will review the likely labour market and organisational repercussions if nurses pay determination is devolved. It also discusses the future role – if any – for the Review Body.

Scenarios of change

In order to structure this review, three scenarios will be used for illustrative purposes. The first scenario outlines the 'limited flexibility' option. It envisages a continued role for the Review Body in an independent capacity, setting national rates, with local managers free to 'top up' pay by local supplements relating to performance or to labour market pressures. The second scenario, 'extended flexibility', retains a national minimum wage setting mechanism for nurses, but assumes a much greater proportion of the paybill is allocated at local level. Pay rates at or above the national minimum are determined locally, rather than pay supplements. The third scenario – 'total devolution' – is based on the assumption that by the mid 1990s most nurses are employed in units which are 'free' to establish their own pay rates and payments systems. This could occur if the majority of employing units in the NHS become self governing trusts.

This second scenario appears to conform most closely to the Department of Health outline proposals for a 'target average' pay increase (TAPPI), to be recommended by the Review Body. A proportion of the annual increase in the paybill would be on basic pay for all staff, and a proportion would be available for local management to allocate as they saw fit, on such grounds as performance or 'shortage'.

This outline proposal, which as the Review Body notes combines pay flexibility and performance related pay, would rely on financial controls at the centre, with little attention given centrally to labour cost and pay information. The Review Body has voiced concerns that 'without adequate central monitoring of pay levels and of the supply and demand for staff, the Department will not be able to tell us, in future evidence, whether or not their pay strategy is proving effective' (Review Body, 1992, para.31,).

At the time of writing, the Department's proposals are only in outline form. It is apparent however that their main thrust is to retain central control over the paybill, and that recruitment and retention implications are of secondary importance. No indication is given as to what proportion of the total pay increase could be used flexibly.

The three scenarios outlined above represent three main options open to government, management and unions. Some of the likely characteristics and effects of each payment system are summarised in Box 12.

'Limited Flexibility'

The 'limited flexibility' option can be seen as fulfilling the requirements of some of the management interviewees, who wished to be able to respond to local labour market issues or to reward performance of individual nurses or groups of nurses. In many respects, this option conforms to the system outlined by the NAHA/King's Fund working party on NHS pay. However, that system was intended for non Review Body staff, because the working party did not think that 'those groups where the NHS is the monopsonistic employer should be entitled to receive this local premium precisely because to do so would lead to large scale poaching of staff from one NHS employer to another with no effect other than to raise the levels of pay' (NAHA/King's Fund, 1987; see also King's Fund, 1988).

The limited flexibility option would have only a restricted capacity for pay variation, which would be above the level determined by the Review Body. At simplest, the system could be based on a national grading structure, with optional additional pay increments awarded according to criteria for merit, performance or 'shortage'.

The main requirements for local management under this scenario would be some enhanced capability in labour market analysis, improved staffing information, and the ability to determine the cost effectiveness of pay and non-pay related alternatives in recruitment, retention and

12

NHS NURSES PAYMENT SYSTEMS: THREE SCENARIOS

	1 Limited flexibility	2 Extended flexibility	3 Total Devolution
Role of Review Body	**Central**	**Influential, but likely to wane over time.**	**Marginal, irrelevant? Unwanted?**
National Career Grading Structure	**Yes**	**Possible, but likely to be eroded over time.**	**Unlikely**
Pay Variations	**Limited within national parameters**	**Evident between units, between specialties and between individual nurses. Variation above nationally set 'safety net'.**	**Marked, between units, specialties and individual nurses. No national benchmark.**
Role of Unions	**Influential at national level**	**Some influence nationally, variable locally.**	**Variable local influence – none in some units?**
Effect on nurses pay levels	**National recommendations set the 'going rate'. Local supplements may enhance pay for some individual nurses.**	**Some downward pressure. Likely tension between national recommendations and local management requirements. 'Winners and losers' emerge. Cartel effect evident.**	**Local control increases downward pressure due to trade of with non-monopsony groups and because of 'cartel' effect. Individual 'winners and losers'.**

motivation strategies. It is likely that unions and professional organisations would retain a significant level of participation and influence in the system at national level. The limited flexibility above nationally determined pay rates would be unlikely to threaten the integrity of the system as a national pay/career structure for nursing staff. Some variations in pay relativity between individual nurses would occur, but this variation would be constrained within set parameters. A major problem could be maintaining this system if pay determination of other groups of NHS employee is further devolved.

'Extended flexibility'

The 'extended flexibility' scenario envisages a situation in which local management have a much greater influence over the pay levels of individual nurses. Whilst a national minimum rate or annual increase would continue to be set (perhaps by the Review Body) a significant part of the total paybill would be allocated by local management. The 'flexible' element in the paybill, which may be 5–10 per cent in 'limited flexibility', would be much greater in this scenario. The end result would be greater pay variation and over the years the national minimum rate would increasingly become a 'safety net', rather than be an indicator of the likely level of basic pay of nurses in a unit.

Greater competition between units on pay terms would be likely in this system. However, as the possibility of inter-unit competition ratcheting up pay levels became more pronounced, so would the pressure for inter-unit collaboration to maintain pay levels. The DoH's outline proposals on TAPPI would restrain, to some extent, inter unit variations, in net paybill terms.

This option would place greater demands on local management, in terms of resources and expertise, and, whilst the unions could retain a role at national level in influencing national pay rates, these rates could become increasingly irrelevant in terms of actual pay levels and pay variations at unit level. The gradual erosion of the relevance of national pay rates in some private sector industries (eg engineering) could be replicated in the NHS. It is likely that any attempt to maintain a national grading and career structure (eg clinical grading) would lose credibility over time, as variations in pay rates became increasingly pronounced.

'Total devolution'

The third scenario represents the most radical departure from the current system, and retains no significant role for centralised pay determination – either by the Review Body or by Whitley. Pay levels and pay variations between individual nurses and groups of nursing staff are determined locally, either by collective bargaining (if one or more unions are recognised) or unilaterally by

management. Pay relativities with other groups of NHS employees would also be primarily a matter for local level determination; local management would decide how much funding to allocate to different groups of workers in the unit.

Central control over pay levels would be maintained through the cash limited allocation of resources to purchasing authorities. Any additional monies for pay increases would be generated from increased labour utilisation, and skill substitution within provider units. This system would place a much greater requirement on local managers to plan, negotiate, implement and maintain payment systems. If this system was implemented, the current national clinical grading system could not be maintained; individual units would develop their own grading systems and career structures. Improved skills in labour market analysis, remuneration planning and negotiation would be required and, where unions were recognised, similar training would be required for local union representatives.

These three scenarios represent different options, which have to be considered in relation to two major requirements of pay determination – how would paybill costs be controlled, and what would be the labour market effect?

Controlling costs

With the nursing paybill accounting for approximately one third of the running costs of units, and with each trust or DMU responsible for setting its own pay rates, the nursing paybill is likely to be very vulnerable to cost containment pressures. Under any of the above scenarios the nursing paybill is a likely main target for cost control at a local level because of its sheer magnitude, but also because of the potential for skill substitution within nursing, and because the monopsony effect can make it easier for NHS management to control pay levels of nurses than for many other groups of NHS employee.

Pressures to alter grade mix will be equally present in each of the three scenarios, but if total devolution of pay and conditions is implemented there will be much greater scope for management to determine and 'pitch' the cost differential between employing qualified nurses and employing healthcare assistants. As noted in an earlier chapter, local level plans for the remuneration of HCAs often include establishing 'non Whitley' (for which read less favourable, but 'cheaper') conditions of employment in terms of working hours, sickness and absence benefit and holiday entitlement. Similar moves are apparent to reduce the cost of benefits to other trust staff employed on non Whitley terms. Management will find it easier to establish less favourable terms and conditions for non-Whitley groups of employees or for individual employees on 'non-Whitley' terms, than it will to effect a comparable reduction in the terms and conditions of nurses currently covered by Whitley agreements.

However, as long as the Review Body retains its independence, the business plans of unit and trusts (where salaries are the major input) will remain difficult to cost accurately. If the Review Body were to lose the ability to recommend whatever rate it thinks justifiable, in order to facilitate forward planning then it would lose its 'independence'. It could continue to make cash limited recommendations on pay minima as a 'safety net' but over time these recommendations could become less relevant in pay determination at local level.

A case can be made that there are countervailing pressures to the scope for skill substitution. The requirement to assess quality of care, which should arise as a result of the purchaser/provider contract system, could limit the extent of skill substitution or skill dilution, on the grounds that quality of care was being compromised, or that an alteration in grade mix, although 'cheaper', was not cost effective. The report from the Audit Commission (1991) promotes primary nursing and in doing so lends support to this argument. Research from the Centre for Health Economics also sheds light on this issue (Carr-Hill et al., 1992). However, the limited data and information systems currently available to assess costs and outcomes often prevent detailed cost effectiveness analysis of various grade mixes of nursing staff, although there is some evidence from the United States that a higher ratio of qualified staff can be cost effective (Buchan and Ball, 1991).

Labour market implications

The limited employment opportunities for nurses outside the NHS, and the comparatively limited geographical mobility of many nurses means that many NHS units have what amounts to a 'captive' local labour market of nurses, who, if they wish to nurse, will have little choice but to work for that unit. In other labour markets, where a number of NHS units compete to employ nurses (eg large conurbations), managers in each unit will come under increasing pressure to restrain nurse paybill levels by collaborating, formally or informally with other units in setting pay rates.

The potential for 'market forces' to drive up pay levels if the labour market is 'tight' is lower in the NHS occupational groups (nurses, physiotherapists) where there is limited competition amongst employers, than in occupational groups where the NHS is only one of many possible employers. External labour market pressures are likely to dictate a shift in balance of

resources towards the non NHS specific groups where competition is fiercer, and away from groups, such as nurses, where there is limited competition. Research evidence from the United States suggests that local pay determination for nursing staff has not always led to nurses pay being at a level dictated by 'market' pressures; local pay determination in the United States has not prevented high vacancy rates and cyclical nursing shortages.

In labour market terms a move to local pay determination is highly unlikely to lead to a pay 'explosion' for nursing staff. Government and NHS management at national level would not be committed to pay devolution if they believed it would lead to pay inflation. Neither will local pay devolution or 'flexibility' in itself be a panacea for all recruitment and retention ills. An appropriate level of pay may be a pre-requisite for any organisation addressing labour market problems but it is not a solution to these problems. In nursing labour markets, successful employers will be those who have the most detailed appreciation of the labour market characteristics of individual nurses, and target their recruitment and retention activities to match these characteristics.

The Review Body

The plans for changes in pay determination outlined in the previous chapter, and considered generally in the introduction to this chapter bring into question the role of the Review Body. Government ministers and opposition spokesmen are both on the record as being committed to the continuation of the Review Body, but the effectiveness and influence of its role would be severely compromised by any move towards a significant level of local pay determination.

The governing factor would be the extent to which pay determination really is localised. If it is flexibly determined at local level, but within a national framework (eg 'limited flexibility'), the Review Body could set national pay parameters and would retain a central influence. If sufficient individual employing units wished to establish their own pay rates (eg 'extended flexibility'), the role of the Review Body would become more tenuous, and a move towards extended flexibility would be likely to create an unstoppable momentum towards 'total devolution' of pay determination.

Whilst the number of employing units wishing to exercise independence in pay determination remains proportionately small, the Review Body and the clinical grading structure could retain validity – indeed these 'independent' units require a national yardstick against which to measure the effectiveness of their own action. However, by 1993–4 a third 'wave' of trusts could be underway, in total employing the majority of NHS staff, and with two years worth of lessons to be learned from the first wave. It was clear from the case studies conducted for this report that some of the first wave trusts were reserving a radical approach to pay determination for later years. By the mid 1990s it could be the case that the 'total devolution' scenario will have become a reality, and there will be sufficient trusts determining pay at a sufficient 'distance' from the Review Body to bring into question its effectiveness, and its existence. There are already early indications that, in the months after the announcement of the 1992 Review Body recommendations, a number of trusts may be considering 'opting out' of implementing the 1992 award for new, non-Whitley nursing staff (*Nursing Standard*, 1992).

The possibility of the role of the Review Body being undermined in such a way was further reinforced by the 'leaking' of minutes from a meeting of NHS Regional Directors of Personnel in July 1991. Senior NHS personnel managers at that meeting envisaged a move away from Review Bodies by 1994 (*Financial Times*, 27/9/91).

These managers recognised the problems of reconciling local 'business' principles with a national commitment to 'fairness' and equity. Government ministers express public commitment to the existence of a Review Body, but they are also presiding over organisational changes which are likely to, at the very least, undermine its role.

Flexibility or fragmentation?

The scenarios outlined above map out possible routes for change. It is apparent that there are significant pressures from government to alter the current structure of nurses pay determination. Whilst these pressures may be presented publicly in a number of ways, they stem primarily from political and management desire to contain costs – be it at national level or in individual employing units.

The contention that local pay flexibility will improve nurses relative pay levels and enhance nurse recruitment is predicated on the assumption that there will be sufficient additional funding generated through contracts to fund this flexibility, or sufficient additional monies from central resources to underpin a new system. This assumption is untested, and pressure at local level to win contracts and at national level to contain contractual costs will act to limit overall paybill increases.

It is likely that the end result would be that allocation of pay to individual employees would alter significantly with fewer, highly qualified nursing staff being comparative 'winners'. But flexibility also requires that there will have to be comparative losers. Evidence from case studies suggest these 'losers' could be nurse management

and nurses in specialities such as mental illness and mental handicap. If the 'limited flexibility' option is pursued, and the Review Body retained, the extent to which there is variation in pay levels between individual nurses, and between nurses in different units will be constrained. Just as the Review Body has had a 'dampening' effect on year on year pay fluctuations, it would also act as a mechanism to limit the extent of variations between units.

If 'total devolution' is the objective, variations in pay at the level of the individual nurse, and between units will become more pronounced as individual units establish different payment systems, pursue different objectives and develop different funding priorities. The overall allocation of funding to nurses pay will not necessarily be any higher or lower than under an alternative system, but variations in allocation between nurses and between units will be more pronounced.

The Review Body has stated that its objectives are to determine fair levels of pay for nurses, and establish a stable system that safeguards the interests of the community as tax-payer and as user of the National Health Service. By the mid 1990s the role of the Review Body would be severely compromised, if individual employing units and trusts pursue a policy of total devolution. In these circumstances, fragmentation of the system would be inevitable, and responsibility for determining 'fair' levels of pay, and establishing stable systems of pay determination which safeguard tax-payer and healthcare consumer interests would rest primarily with local management. There is some doubt that they currently have the resources to meet this responsibility.

There must also be concern as to how local management in the future could reconcile achieving these objectives with meeting centrally imposed cost containment targets. The nursing paybill is one of the major cost containment pressure points for NHS management, and worthy objectives of 'fairness and stability' will inevitably take a second priority to cost control.

Nurses pay determination has never been simply about pitching pay levels to recruit, retain and motivate. There has always been a tension between political factors (pay more, to assuage public opinion; pay less, to accommodate Treasury and 'taxpayer'), managerial demands (pay enough to recruit and retain, but not more than enough) and trade union and professional demands (pay more, to improve status and secure long term supply of staff).

The Review Body has, in recent years, had to attempt to maintain a balance between these competing pressures. Devolving responsibility for pay determination will not release these pressures, but rather will transfer the burden of maintenance from Review Body to local management. A significant level of pay devolution would undermine the role of the Review Body, and could lead to a net comparative reduction in the NHS nursing paybill. It would not, in itself, 'solve' recruitment and retention problems, and would place considerable demands on local management.

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