KF PROJECT PAPER

NUMBER 39

A New System for Pay Determination for the NHS

a contribution towards the debate

MARGARET McCARTHY

King Edward's Hospital Fund for London is an independent charity founded in 1897 and incorporated by Act of Parliament. It seeks to encourage good practice and innovation in health care through research, experiment, education and direct grants.

A NEW SYSTEM FOR PAY DETERMINATION FOR THE NHS

A contribution towards the debate

MARGARET McCARTHY

King Edward's Hospital Fund for London

A working seminar on the future of pay determination in the health service was held at the King's Fund College on 30 November-2 December and 14-15 December 1982.

Participants

Margaret McCarthy Course Director

Mr D J Downham Chairman, West Dorset Health Authority

Miss J Flindall District Nursing Officer, Oxfordshire Health Authority

Mr J George Regional Personnel Officer, Trent Regional Health Authority

Mr J R Gourlay Regional Personnel Officer, Wessex Regional Health Authority

Mr A Holroyd Regional Administrator, Yorkshire Regional Health Authority

Mrs R Kelly Chairman, National Association of Health Authorities

Mr D J Knowles District Administrator, Victoria Health Authority

Mr A Liddell District Administrator, Hammersmith & Fulham Health Authority

Mr R Nicholls Regional Administrator, South Western Regional Health Authority

Mr C E Price District Treasurer, Milton Keynes Health Authority

Mr G Roberts District Treasurer, Cornwall & Isles of Scilly Health Authority

We had the benefit of discussion with

Mr R Ramsay President of the Institute of Personnel Management

Mr L Cowan Director and Secretary of the Federation of London Clearing Bank Employers

Professor S Kessler Professor of Business Studies at City University

Mr S Taylor and Miss H Williams Hay Management Consultants

Mr A Nicholson Deputy Director, Labour Relations and Legal Department Royal College of Nursing

Mr P Jacques Senior official of the TUC

Mr J James DHSS

Mr B Smith DHSS

FOREWORD

There can be few more important current problems in the management of health services than pay determination. The 1982 dispute severely affected services, harmed patients and left a legacy of bitterness. That has also been true of protracted pay disputes in health services in other countries such as Canada and France. Health services can only function through the willing cooperation of large numbers of people from different disciplines. If any one discipline takes industrial action the effect can be catastrophic, as with the failure of a single key part in an engine. Thus a hospital's work is drastically slowed if sterile supplies are not available or the boiler is not functioning.

Not only are health services – particularly hospitals – exceptionally vulnerable to industrial disputes, they also seem fated to provide a battleground for clashes between government economic policy and the pay aspirations of the many groups who work in the health sector. Whatever government may claim the truth is that decisions about government expenditure on health services determine within narrow limits what is available to meet pay claims and vice-versa. Wage rates in this sector cannot be settled by any means other than some form of bargaining among three parties, namely staff representatives, management and the paymaster (the government). Those who stand to suffer most in the process are none of these three groups, but patients.

Memories are often short about the harm done by disputes. An absolute certainty, however, is that disputes as damaging as that of 1982 will recur unless we find better ways of reaching bargains about pay for *all* groups of health services staff. The time to look is now, as the present team of ministers has recognised. When a dispute breaks out, it is much too late to try to reform the mechanisms for settling it. Thus the problem is not only important, it is also urgent.

Lady McCarthy, during a Visiting Fellowship at the King's Fund College, has acted as planner and convenor for a group of health services chairmen and senior managers who have produced this report. They worked with experts in pay determination and arbitration from within and outside the NHS. I have great admiration for the way that they set about the difficult

task of producing viable reform proposals. That does not necessarily mean that their recommendations represent the only possible answer to the problem. I am absolutely confident, however, that they comprise a contribution that deserves very close attention from everyone who wants to find a better way.

Robert J. Maxwell
Secretary
King Edward's Hospital Fund for London

INTRODUCTION

1982 saw the most protracted industrial dispute that has ever occurred in the National Health Service. The length and strength of the dispute surprised many observers and demonstrated that the traditional way of determining pay levels in the health service cannot be revived. From an early stage the need for a new and different way of determining pay was demanded both by the protagonists and the commentators. 'If there is one remaining area of common ground between the Government, the employing authorities and the trade unions it is that something viable has to be constructed . . .' (Dyson, 1982) 'If the aspiration is to minimise destructive conflict in the NHS . . . then the aim should be to draw as many workers as possible into arrangements designed to recognize conscientious service . . .' (Times editorial 1982)

On 16 September 1982 the Secretary of State made an offer, as part of his negotiation with the trade unions and professional associations, to enter into talks designed to produce different long-term arrangements. In answers to parliamentary questions he repeated these offers to enter into talks about 'long-term arrangements with those in the health service (which would) concern factors like comparability, but also recruitment, retention and what the nation can afford'.

One of the marked features of the dispute was the feeling of exclusion felt by NHS management, which has undoubtedly contributed to the belief that the Whitley system has proved to be a failure. Considerable anxiety has also been expressed by management that they would have no input into the new arrangements, and their advice would not be sought.

The King's Fund decided, in the light of all these events, to hold a working seminar for senior management in the NHS so that they could discuss with experts in the field of pay determination the problems of pay in the NHS and through such discussions possibly devise a system which might be seen as management's contribution to the debate about the future. The participants in the seminar were all managers (either lay or professional) who had expressed interest and concern about the subject or who were already deeply involved in the Whitley system.

This report contains the results of our deliberations. The first section outlines our aims and assumptions. Further sections deal with the requirements and options for a pay determination for the NHS, ways of minimising industrial disputes and a possible way of dealing with the problems of the the cash limit.

AIMS AND ASSUMPTIONS

The group started its discussion by making some assumptions. The first of these was that the present method of determining pay was dead and that there was no possibility of reviving it.

A brief glance at the history of pay determination in health service reinforces this conclusion. For a number of reasons a system of informal links had grown between grades in the health service and defined external comparators. Some of these comparators grew as a result of the history of the provision of health services before 1948, and have much to do with the unions recruiting in the health service. The link between ancillary workers and local authority manual workers came about because local authorities ran local hospitals, and the same unions recruited in both organisations. Similar links were quoted between administrative and most scientific and technical staff and the Civil Service. The links were informal, and quite often illogical in the sense that they were not based on like work comparisons.

But, however informal and illogical these links were, they served to give some stability to pay negotiations. However, since 1980, the links have for various reasons been broken. Some commentators have argued that the protracted, and sometimes bitter, dispute of 1982 was caused partly because, with the links having been broken, trade union negotiators were 'swinging' in a vacuum without reference points. The TUC unions have expressed a determination to re-establish these links, but this seems to be an unrealistic, and even undesirable aim, since most of them rest on illogical and haphazard premises.

The second assumption which the group made was that any future arrangements for pay would partly rest on some form of comparability. We

were encouraged in this belief by the already quoted statement by the Secretary of State that comparability would be one of the factors in the new long-term arrangements.

The idea of comparability as a way of determining pay in the public sector is very old. The principle was accepted by the Select Committee on Public Expenditure in 1828. It said 'First find out what the (salaries) are in commercial and other establishments and then examine whether more talent and trust are required ... and, if so, then make the salaries in the Public Office proportionately higher'. The Playfair Committee of 1870 took a roughly similar view. It recommended that the Civil Service should pay 'remuneration such as would attract men of liberal education who would otherwise go to the open professions'. The debates and investigations into Civil Service pay have since that time been about the levels at which pay should be set after comparable rates have been established and whether the Government should pay higher rates in order to be seen as a 'model employer' (McDonnell Commission, 1912) or whether 'the responsibility of government is limited to paying what is necessary to recruit and retain an efficient staff' (Anderson Committee, 1923). The Tomlin Commission agreed with the criterion laid down by the Anderson Committee, but asserted that comparability is the best means for achieving that criterion.

The recommendations of the Tomlin Commission were followed until the outbreak of the 1939 war, when flat rate increases were paid. After the war there was a return to centrally negotiated settlements. Dissatisfaction with the methods of settling pay and with actual pay levels led to the establishment of the Priestley Commission (1953). Priestley's principal recommendation was that civil service pay should be based on 'fair comparison with the current remuneration of outside staffs employed on broadly comparable work, taking account of differences in other conditions of service.'

Priestley recommended a very detailed method of collecting outside pay rates and went into considerable detail about the arrangements which might be made for putting into practice the principles they were commending. The

system they proposed was further refined and modified in the light of experience. But in spite of these refinements, it was not regarded as entirely satisfactory either by successive governments or the Civil Service unions. The Megaw Committee was established in 1981 to consider the whole system and make recommendations on the principles and the system by which the remuneration of the industrial Civil Service should be determined.

We feel it fair to assume that these principles would be considered suitable for the NHS for three reasons. First, because although there are substantial differences between the Civil Service and the NHS, there are fundamentally similar characteristics. All the finance for both comes from the Exchequer; unionisation is high in both; there is no direct product which is sold on the open market and therefore the pressure of market forces is at least reduced and the issue of levels of pay is a matter of public policy.

The second reason is that comparability is not unknown in the health service. It has been used to establish pay levels in groups who had no traditional external links. The Pilkington Committee (1960) investigated doctors and dentists and recommended that comparability should be used to set pay levels. This report led to the establishment of the Doctors and Dentists Review Board whose recommendations are based on comparability exercises. There have also been several *'ad hoc'* reviews of various groups in the health service – the NPIB and the Standing Commission for Pay Comparability (Clegg Commission) for ancilliaries, Halsbury and Clegg again for nurses – all of which have based their recommendations on some comparability studies. And recently the Secretary of State has proposed the setting up of a review board for nurses and professions supplementary to medicine (PSMs) which will undoubtedly again use comparability studies as a basis on which to recommend levels of pay.

Our third reason for assuming that comparability would play a major role in any future pay systems is that we accepted that it is the system which to a considerable extent influences, either formally or informally, wage bargaining throughout the private sector. As one of our visiting speakers

observed 'all pay is based on some sort of comparability'. This assertion is amply borne out by published studies. Ross (1948) argued that unions have an interest in outside comparison because of their competition with other unions. Daniel's (1973) study found that comparisons were a major issue in bargaining demands, a finding confirmed by practitioners (for example, Jones, 1973; NPBI). Studies by Burton and Addison (1973) show that employers also use both internal and external comparisons in determining pay scales. Runciman (1966) in his study on deprivation shows that people are concerned with their relative position in social groups and draw comparisons (of which the most important is the pay comparison) with others in like circumstances to assess that position.

REQUIREMENTS AND OPTIONS

Having established these assumptions as being common to the group, we turned to consider in detail what sort of system of pay determination, based on more formal comparability, might be suitable for the health service. In considering this we bore in mind the government's evidence to Megaw 1982. In their evidence they say that in approaching a new system they 'start from the proposition that there is a substantial public interest in the recruitment and maintenance of an efficient and fairly remunerated Civil Service; in the orderly conduct of business of Government and services to the public; and in the maintenance of good industrial relations in the Civil Service ... The Government recognises that in a free society it is not possible to impose pay and conditions by fiat; and that there is an inevitable cost to the Exchequer and society if pay in sensitive areas is settled by the process of industrial confrontation.' It is fair to assume that the government would feel the same about the NHS.

A number of commentators have suggested that the recommendations of the Megaw Committee could be used as a basis for a different system of pay determination for the health service.

Because of this, the group spent a considerable time examining the recommendations of the Megaw Committee, together with a member of the Megaw Committee, Mr R Ramsay.

Megaw outlined the problem of pay determination in the Civil Service as having three characteristics.

1 Half a million people not subject to the profit/loss discipline;
2 an employer who possesses vast monopoly power;
3 a labour force which possesses enormous power to disrupt, with grave consequences.

The Committee recognised that any solution which they suggested must be acceptable to both sides; and it must also be a solution which could work, not an 'academic' one. The system would have to be acceptable to the community as a whole. It should be capable of enduring for a long time. It has to be capable of dealing with changes in government, and government policy. It has to be capable of dealing with an unstable economic situation. The system has to be capable of dealing with the requirements of the Civil Service which the Committee identified as being the need to:

a) recruit
b) motivate staff
c) satisfy management's need:
   i) to run the service efficiently
   ii) to aid improvements in efficiency, productivity and the need for change.

Any pay determination system of this kind would need to meet the national economic situation as the government and the community saw it – subject to the overriding view of Parliament. It should minimise the possibility of pay disputes in the public interest. Finally the system should not remove from the parties their essential responsibilities.

We recognised that the government has not given a response to the recommendations of the Megaw Committee. Nevertheless, we found that much of the analysis of the problem, and many characteristics of the best solution, would fit the health service.

The most fundamental and significant difference between the two is, of course, that in the health service the government, although paymaster, is not

the employer, unlike the Civil Service where both roles are combined. The health authorities are the employers for NHS staff and, thus, three sides have to be considered in any problems and any suggested new system. We identified other significant characteristcs which we believe differentiate the health service from the Civil Service. We agreed that the problem of pay determination in the health service has six characteristics, three of which resemble those of the Civil Service and three others which are unique. These characteristics we defined as being:

1 One million people not subject to the profit/loss discipline.
2 The employers (health authorities) have a quasi-monopoly.
3 The employees have enormous power to disrupt, but there are possible constraints of public opinion and higher than normal work ethics and/or job satisfaction.
4 The largest single group of employees (nurses) have no external comparators.
5 There is potential tension between the centre and the periphery; that is to say, between the government as paymaster and the health authorities.
6 There is local accountability laid on health authorities for provision of service.

When we came to consider what the determinants of any pay system for the health service should be, taking into account these differences in characteristics, we thought that the first nine elements listed below had a relationship to those which Megaw outlined, but that the NHS needed an additional four. (We omitted the overriding view of Parliament in the matter of pay determination in the health service, because of the delegated duty of the Secretary of State in pay matters outlined in the NHS Act of 1977.)

The elements which we identified as being necessary for any system in the health service were that it should:

i) aid recruitment, retention and motivation of staff;
ii) be acceptable to three sides in any negotiation – government, employers and staff;
iii) be acceptable to the community at large;
iv) endure for a long time;

v) be able to cope with changes in government;
vi) be able to cope with an unstable economic situation;
vii) take account of national economic circumstances;
viii) be capable of dealing with service needs which we defined as being efficiency, productivity and need for change for the employer, and motivation and recruitment for the employee;
ix) minimise the possibility of pay disputes;
x) not remove from the parties their proper/essential responsibilities (which we regard as showing the necessity for collective bargaining)
xi) not prejudice this negotiating/collective bargaining system by 'early' announcements of the cash limit;
xii) be capable of influencing the final cash limit;
xiii) produce a compatible outcome for all groups of staff.

We did not give these requirements any weightings in considering possible new systems, although we recognised that some might be regarded as more important and achievable than others. For example, we accepted that everyone, government, employers, staff and the community at large, would regard the minimisation of industrial disputes as being a most important requirement of any system. We also agreed with speakers who told us that internal relativities were important to establish and maintain. If internal comparisons are felt to be fair, then the system stands a much better chance of being acceptable to the staff within it.

We examined the five options set out by Megaw as being those which covered all forms of pay systems. We agreed that these options were the only possible ones. They are:

1 Diktat
2 Unfettered free collective bargaining
3 Automaticity (that is, automatic indexation)
4 Third party decision (that is, pay review)
5 The 'Megaw' solution – which we have defined as informed, constrained collective bargaining.

We then tested each of the options against the characteristics that we had defined. We thought it important that this should be done because we knew that each of the options has been advanced, at some time, as a solution to the

problem of pay determination. The results of these tests are given in considerable detail.

Option one: Diktat

We defined this as being a figure for the quantum and distribution of any pay award being announced by the government as paymaster with no collective bargaining, and no necessary comparisons, either internal or external.

We thought that the positive features of such a system would be that:

i) it might be acceptable to the community as a whole;
ii) it would cope with changes in government policy;
iii) it would cope with an unstable economic environment and would take account of national economic circumstances;
iv) it could, in certain circumstances, be capable of dealing with service needs;
v) it would be capable of influencing the final cash limit;
vi) in certain circumstances again, it would produce a compatible outcome for all groups of staff.

Against these positive features, we thought that negative sides of such a system would be that:

i) it would not aid recruitment, retention and motivation of staff;
ii) it would not be acceptable to any of the three sides. (The government had already rejected the idea in its evidence to Megaw);
iii) it would not endure for a long time;
iv) it would certainly not minimise the possibility of pay disputes – in fact it is the system which is capable of producing maximum disruption;
v) it would remove from the parties any responsibility for pay.

We regarded this option as being unsuitable because of these severe disadvantages.

Option two: Unfettered free collective bargaining

This option seemed to have even less to recommend it. There were few positive features:

i) it could aid recruitment, retention and motivation of staff;
ii) it could – at some price – deal with service needs;
iii) it would, by its very nature, embrace collective bargaining;
iv) it might influence the cash limit.

Against these positive elements must be set:

i) it would certainly be unacceptable to both the government and the health authorities;
ii) it would not be acceptable to the community at large;
iii) it would not endure for a long time;
iv) it would not cope with changes in the government;
v) it would not cope with an unstable economic system;
vi) it would take no account of national economic circumstances;
vii) it would not minimise – again it could maximise – the possibility of pay disputes;
viii) it would not produce compatible results for all members of staff.

We dismissed this option as being totally unworkable.

Option three: Automaticity

This option appeared to have rather more to recommend it. We were aware that it did work for certain groups in the community – notably police and firemen. But the NHS covers many workers and we doubted whether all of them could be treated in a uniform way. It does appear, however, that automaticity might work for some groups – notably nurses.

We summarised the positive features of this option as being:

i) it could aid recruitment, retention and motivation for some groups;
ii) it would be acceptable to the community at large for some groups;
iii) it would cope with changes in government policy;
iv) it would minimise the risk of industrial disputes for those groups who obtained it;
v) cash limits could be adjusted early and therefore would be flexible.

Against this, however, we believed that:

i) it would be unacceptable to the government;
ii) it would be unacceptable to the community as a whole if applied to other than a very self-contained 'popular' group such as nurses;
iii) it would not endure for a long time;
iv) it would not take account of government economic policy;
v) it would not take account of national economic circumstances;
vi) it would not deal with the needs of the service – particularly management needs;
vii) it would remove from the parties any responsibility for collective bargaining.

We believed that if the government were persuaded to grant automaticity to one (or possibly two) groups in the health service, this would be divisive and would also distort internal relativities.

Option four: Third party decision

We considered this option in more depth. We knew that the government had already offered such a system to the nurses and professions supplementary to medicine (PSMs). We knew also that such a system had been in operation for doctors and dentists for the past twelve years. It holds several attractions for NHS management. We summarised the positive features of pay review as being:

i) it would aid recruitment, retention and motivation of staff;
ii) it could be, for some groups at least, acceptable to the government. As we have said, it holds some attraction for management and appears to be acceptable to some staff organisations;
iii) it would be acceptable to the community for certain groups of staff;
iv) it could cope with an unstable economic situation;
v) it could influence the cash limit and make it more flexible.

We saw three major disadvantages, however.

1 The government has made it clear, both in its present offer to nurses and from its actions in the past, that it would not necessarily feel bound to

accept any recommendations of a review body. Recommendations of all review bodies have been set aside, or trimmed, by successive governments. However, such setting aside, or trimming, when applied to a group of staff whose share of the pay bill is small, need not have particularly disastrous consequences because extra money can be given at a future date without unduly affecting cash limits. Indeed, a glance at the history of the various review bodies – for example 'Top People's' and Doctors and Dentists – shows that it seems to have become a common practice for successive governments either to set aside or to trim recommended awards for two or three years, and then to agree to a larger award in order that these groups can 'catch up'. It would clearly become more difficult if large groups of staff were involved.

The question of the right of the government to set aside or trim recommendations of review bodies is a sensitive one. We recognised the need for a government to have and to exercise such a right. Even if the review board is required to take into account the government's ability to pay, the results of review may produce a figure which does not take into account either an unstable economic situation or national economic circumstances. Once the government's right has been exercised, however, the whole system becomes more fragile and less capable of enduring and the possibility of industrial disruption becomes greater, particularly if pay review is granted to groups who have not discounted industrial action.

2 Pay review, when applied only to some groups of staff, can grossly distort internal relativities, particularly if the review board does not have internal relativities as part of its terms of reference. We doubted whether pay review could show sufficient flexibility towards the needs of the service, even if its terms of reference required any review board to take account of such a need. One of the consequences of this inflexibility is to produce a feeling of 'unfairness' in those groups who are excluded from pay review. This feeling of unfairness could lead to considerable industrial disruption.

3 We also felt that it would be unhelpful to remove large numbers of staff from the collective bargaining process. We were reminded that the

government itself, as we have pointed out earlier, supported the principle of collective bargaining in its evidence to Megaw.

For all these reasons, we finally decided that a wholesale pay review system was not suitable for the NHS. But, even if we had not been convinced by argument, we would have had to dismiss such a system because of the answer given by the Secretary of State to a question asked in the House on 18 January 1983. 'I do not envisage a body such as the Review Body to be set up for other staff groups' (that is, other than nurses and PSMs). And later: 'It has been clear from the beginning that there will be no question of the Review Body covering, for example, ancillary workers, administrative workers and clerical workers. We have made our position clear.' (Hansard, 18 January 1983)

Option five: The Megaw solution – constrained collective bargaining

Having rejected all other options, we turned again to the Megaw report to consider the option for a pay system at which they had arrived for the Civil Service.

In deciding on this system the Committee had regard to five factors:

i) the importance of money comparators;
ii) the need to compare quantifiable fringe benefits;
iii) the need to list unquantifiable fringe benefits;
iv) the relative efficiency of the service plus the need to produce changes in productivity and to reward effort;
v) the need to take account of the national ability to pay.

Their proposed system based on these factors was for an independent pay board which would suggest comparators to the parties, would supervise the collection of pay data and the method used to determine the comparators, and would publish an annual report so that the figures and system used would be available for public scrutiny. When the information had been published and the range of pay was known, the parties would be free to bargain around a point in the published rates. The Committee suggested that bargaining should be confined to the two middle quartiles. To assist in

the resolution of possible conflict, arbitration should be built into the system.

We considered how such a system might be applied to the health service. We agreed that the five factors which the Committee listed as being important for the Civil Service were also important for the health service. We also agreed that an independent data base was an important prerequisite of any bargaining system. We thought that the results of the information collected about comparators should be published so that the system would be seen to be open. And we thought that there should be a built-in constraint on the range of figures around which the bargaining should take place. We also believed that third-party intervention should be built into any agreed system in order to minimise industrial conflict.

Having agreed so far with the principles behind the Megaw Committee's proposed option, we then considered in detail how the system for the health service might be constructed to take account of them.

We had to bear in mind that the nurses and PSMs had accepted, in principle, the offer of the Secretary of State to grant a system of pay review for them. We felt that it was very important to try to devise a system for the rest of the service which was not incompatible with this review system. Because we believed that pay review can distort internal relativities, we felt that a single information gathering body should be employed both for the review body and for any pay information board which might be set up for the rest of the staff. We thought that this should probably be the Office of Manpower Economics (OME). We thought that it was likely that factor comparison would be needed for nurses and PSMs since the Clegg Commission had already established the impossibility of using whole-job comparisons for these groups of workers. On the other hand we believed that, although factor comparisons will be needed for some jobs in the other grades and professions, there are many jobs for which the whole job comparison method would be valid.

We do not know at this stage how the pay review board for nurses will be set

up. For the Civil Service, Megaw suggests that the board should be composed of independent members who receive evidence from the parties on the sort of comparisons which should be used, but who decide for themselves what should be the comparators. Megaw believed that the clear independence of the board would ensure that its finding would be acceptable to the community at large. We believe that it is likely that such a board will be set up for nurses and PSMs, particularly since this is the way in which the Doctors' and Dentists' Review Body is composed.

We considered this option for our proposed system, but came to the conclusion that we would prefer to see a board made up of representatives of management and staff sides. We thought such representation would reassure the parties about the 'fairness' of the system. The board would agree the choice of comparators and the methods of comparison to be used, being advised by the independent information unit. We thought that there should be five representatives of management and five staff side members, with an independent chairman, appointed by the Secretary of State, and acceptable to both sides. We recognised that the Secretary of State has an interest in the choice of comparators and the methods used, so at least one member of the management side should be a departmental representative. We thought that an independent chairman is important, to avoid any possibility of deadlock between the parties in the choice and method of comparison.

The board, having agreed comparisons, would instruct the information unit to collect and present the information, which it would then publish. Our pay board would not, as review bodies do, make recommendations about any possible pay award, but would simply comment about where the inter-quartile lay, and what would be the range of figures around which the parties would bargain.

Our system has begun to depart radically from the system proposed by Megaw for the Civil Service. This is inevitable because of the different characteristics of the health service which we have previously identified. The outstandingly different characteristics is that in the health service there are

three sides to the bargaining process, the unions, the management and the government. Any system suggested for the health service must recognise this fact and seek to accommodate to it. To devise a system for the Civil Service is much easier, since the government is the employer. There is no possibility of differing voices on the management side; and the management side can express a corporate view.

To discover the corporate view of the health service is much more difficult. The government, while it does and must have a view about levels of service and pay in the health service, is always at pains to point out that it is not the employer. The regional and district health authorities are the employers and, in principle, at least determine the view of the management side. It seems at the moment to be virtually impossible to find out what is the corporate view of the NHS. The Whitley Councils have always had the charge levelled against them that the agreements about pay which they make take no account of the circumstances of different regions of the country and their ability to pay. In consequence, the effect on the level of service of any given pay award can differ radically throughout the country. Members of Whitley Council reply by pointing out that they find it impossible to get the sort of information which would enable them to make more sensitive decisions. They also find it difficult to discover what the service as a whole would regard as a reasonable pay settlement.

We believe that some mechanism for collecting and presenting the corporate view of NHS management is essential for our proposed system of pay determination. Our system depends at every stage, from the pay board to the bargaining unit, on there being an overall management view, particularly if the system is to meet the criteria which we have spelled out earlier as being necessary. We agreed that such a corporate view must come from existing arrangements in the service, rather than trying to invent new ones. We sought for a mechanism which has clear, recognised and formal accountability both to the Secretary of State and to the service, and decided that such a mechanism could only be found in the regional chairmen meetings.

The regional chairmen have already been given a great deal of formal accountability through the setting up of the review system by the present government. Regional chairmen are required now to meet regularly with their district chairmen in order to review with them the state of the service and the progress which is being made by each district towards achieving its priorities. These meetings could provide the opportunity for district chairmen to discuss with regional chairmen their own views and priorities on pay matters. The regional chairmen already meet regularly with the Secretary of State, and these meetings could be used by the Secretary of State and the regional chairmen to agree pay strategies in the light of service needs as outlined by district chairmen. Additional information and proposals on pay can also be given to regional chairmen through the 'uni-disciplinary' meetings of regional chief officers.

But we feel that the regional chairmen will need a more systematic basis on which these briefings can be based. At present there is no investigation or even crude analysis of pay matters by NHS management. The lack of such information is sorely felt by both management and staff, and is a constant source of complaint by Whitley management sides. If, as we hope, regional chairmen are given the responsibility for becoming a 'national board of directors' in a new pay system, they will need assistance in correlating and supplementing existing information to achieve a view across the service. We propose that a pay research unit should be established as part of the secretariat arrangements which already exist for regional chairmen. This unit should also be available to assist Whitley management sides during negotiations. It should be staffed from within the NHS.

We acknowledge the critical role which the Secretary of State has to play in the determination of priorities in service and pay in the NHS. We also believe that the Secretary of State would like to see NHS management playing a greater role in the determination of these priorities. We believe that our proposals for the new role of regional chairmen will fulfill what we see as crucial criteria.

We have used the analogy of the regional chairmen as a 'board of directors'

in pay matters. Analogies are frequently dangerous, but in the narrow sense in which it is used here it can be helpful to illustrate how we see the system working. We are aware that boards of directors of large companies decide the parameters and overall constraints within which their negotiators can bargain. We think that this should be the role of the regional chairmen, after they have consulted their district counterparts.

We do not believe, however, that the regional chairmen should themselves become direct negotiators. We think that negotiations should remain in the hands of the Whitley Councils. In making these proposals, we are aware of the criticisms which are made of the Whitley system, not least by those who serve on Whitley committees at present. We agree that the functional Whitley Councils have suffered for some time because of the compartmentalised way in which they work; from their perceived, and sometimes actual, remoteness from the service and from their inability to frame decisions which meet the needs of the service as a whole. But we believe that the Whitley system will be strengthened by the proposals we have made. The regional chairmen having agreed priorities with the Secretary of State can instruct the Whitley functional councils on behalf of the service about the agreed priorities. These priorities would act as parameters within which the councils would be expected to negotiate.

We would not propose any amendment to the membership of the management sides of the council. We believe that at least one departmental member should continue to sit as part of the management side, in order to safeguard the interests of the Secretary of State. We acknowledge, however, that the role of the Department will change. At present, the departmental members of functional councils are the only people who have detailed knowledge of what is happening across councils. When the regional chairmen are responsible for instructing the councils, then all the councils will know the overall priorities for the service. They will also have, as we have suggested, the assistance of the pay research unit for the knowledge and analysis of service needs, which they do not have at the present time.

We do propose one change in the present Whitley system. Another charge

levelled against the functional councils is their lack of accountability. We believe that this is true, and, to strengthen the accountability of Whitley, we propose that the chairmen of each council should be appointed by the regional chairmen after consultation with members. The Whitley chairmen should then take part in discussions with regional chairmen when priorities are being determined, and when direction as to policies and parameters are given to the individual councils.

We recognise that in proposing this system, however, a serious problem arises for Scotland and Wales. Because of the different structures of the NHS authorities in these countries, they would not be represented at regional chairmen level. However, this is only part of the difference which exists between the three countries. Service priorities are decided in a different way in Scotland and Wales from pay questions. Since we believe that the two questions cannot be separated, we are forced to suggest that the whole question of pay determination should be devolved to Scotland and Wales so that it can be dealt with in the same way as service priorities. We believe that this is a practical solution. We recognise, however, that there may be some transitional difficulties.

The system of pay determination which we are proposing begins to look like this:

i) It should be based on the principle of comparability.
ii) In order to establish the type and method of comparison, a pay board should be set up consisting of five representatives of the staff sides, five representatives of management (including at least one departmental representative) and an independent chairman, appointed by the Secretary of State and acceptable to both sides.
iii) The board should be assisted by an independent agency which would carry out the actual work producing the comparators. This agency should be the same for the pay board and the pay review body to be set up for nurses and PSMs.
iv) The board should publish annually the results of its work and the range of earnings produced.
v) Negotiations should be carried out by the existing functional Whitley

Councils, but the bargaining should be constrained by a pre-determined range of figures within the published report of the board. We suggest that the inter-quartile would be the most suitable range.

vi) The regional chairmen should together be responsible for formulating the corporate view of NHS management, through consultation with district chairmen and regional groups of officers. These officers should, in turn, be responsible for collecting the views of their district counterparts.

vii) The regional chairmen's secretariat should be enlarged by the creation of a pay research unit to collect and analyse crude data so that the regional chairmen can form an overall view of service needs. The pay research unit should also be available to assist the functional Whitley Council during negotiations.

viii) The regional chairmen, after discussion with and agreement of the Secretary of State, should inform Whitley Councils of the service priorities and parameters within which the councils should negotiate.

ix) In order to ensure Whitley Council accountability the chairmen of Whitley Councils should be appointed, after consultation with members, by the regional chairmen.

We can examine this system against the requirements which we have previously identified as being necessary for pay determination in the health service.

We believe that it would work.

It would also:

i) aid recruitment, retention and motivation of staff;
ii) be acceptable to the three sides – government, employers and staff;
iii) be acceptable to the community at large;
iv) endure for a long time;
v) cope with changes in government;
vi) cope with an unstable economic situation;
vii) be capable of dealing with service needs;
viii) not remove from the parties their essential responsibilities.

So far, our system appears to cover most of the necessary criteria. But three essential characteristics remain to be discussed:

1 the minimisation of industrial disputes;
2 the prejudicing of the system by 'early' announcements of the cash limit;
3 the capability to influence the cash limit.

We recognised that unless the system we proposed could show that it could help to resolve these difficult areas; it would stand no chance of success.

As we have said earlier, the Megaw Committee recommended, and we agreed, that some recourse to arbitration is an essential part of any pay determination system.

MINIMISING DISPUTES

The principle of arbitration is generally recognised to be important in limiting industrial action. Parties use arbitration for many different reasons. Sometimes, they seek for a third party to 'get them off the hook' – that is to release them from an impasse into which they have talked themselves. On other occasions, one or other parties will use arbitration as a device for agreeing to a decision which they know to be unpopular with the group they represent. Often, parties seek arbitration when they have reached the limit of possible acceptable solutions and need a disinterested third party to look at the problem with a fresh eye. The lack of any form of arbitration in the health service has long been felt by both management and staff sides, and has sometimes led to unnecessary escalations of disputes.

We examined in some depth the whole principle of what we prefer to call 'third-party intervention'. In broad principle third-party intervention can take one of three forms: conciliation, mediation and arbitration. These may be defined as follows.

a) Conciliation – where a third party helps to reconcile two opposing points of view, without recommending a course of action to either side.
b) Mediation – where a third party listens to the arguments of both sides and then makes recommendations to solve a dispute. Neither party is

bound, however, to accept the recommendations of the mediator.

c) Arbitration – where a third party listens to the arguments on both sides and then makes a decision about the resolution of the dispute which both sides have agreed in advance to accept.

There are clearly significant differences between these forms of third-party intervention. For example, because in arbitration both sides are committed to accept his solution before the third party intervenes, it is customary for both sides to agree to go to arbitration. Agreements which allow for one side to demand arbitration without the agreement of the other *(ex parte)* are rarely successful in solving disputes.

On the other hand, it is quite customary for agreements which provide for mediation to allow *ex parte* reference. And although the mediator's recommendations are not binding, the parties normally take them into consideration, and usually conclude agreements which are influenced by the mediator's report. It is also quite usual for one side to seek conciliation.

We believe that all three approaches – conciliation, mediation and arbitration – should be open to management and unions in the health service. Megaw recommended for the Civil Service that recourse to arbitration must be jointly agreed by both parties. We would support this. But Megaw recommended mediation as an alternative to arbitration for the Civil Service. We do not accept that mediation should be an alternative. We propose that an agreement on third-party intervention should contain the right to both mediation and arbitration, and the choice of mediation should not exclude later recourse to arbitration. We thought that conciliation, though an important part of dispute resolution, did not need to be written into a formal agreement, but that it should be made clear that either party during the course of negotiation could seek conciliation at any stage.

We then discussed who should be the mediators/arbitrators. We recognised that there are arguments for making each dispute self-contained and consequently bringing in fresh arbitrators (or mediators) on each occasion. However, we believe that the advantages of having an uncommitted

arbitrator are outweighed by the disadvantages of asking someone to make important decision about a complex service with perhaps little knowledge of its difficulties.

We preferred the idea of a standing arbitration tribunal, since we could be more certain that we should have people who not only had an opportunity to learn about the health service, but also, since they would be taking a series of decisions, would be more alive to the consequences of their recommendations. We thought too that the tribunal should consist of more than one person, so that we are proposing that a standing arbitration tribunal should be established with three members; one member drawn from a panel recommended by management and one from a panel recommended by the staff side. We thought there should be an independent chairman. We considered the example of the Central Arbitration Committee, which has a chairman, and a number of deputy chairmen, all of whom are appointed by the Secretary of State, with the agreement of the two sides. We like this system and recommend it for the health service. The deputy chairmen would chair individual references. Such panels of side members and deputy chairmen would provide specialised knowledge for individual references. Each functional council would have recourse to the tribunal.

But we feel that the Secretary of State's position in the whole field of arbitration should be safeguarded. Although, as we have said, we feel that mediation should be *ex parte* since the recommendations are not binding, agreement to go to arbitration (which would be binding) could only be reached through a unamimous vote of the management side. The Secretary of State could then exercise his preference through his departmental representative.

DEALING WITH CASH LIMITS

The problem of the cash limit is one which greatly exercised Megaw, and ourselves, since it is a problem common to both the Civil Service and the NHS.

Megaw outlined the problem thus:

> 'The need for the Government to give some indication of its assumption on pay before the negotiations begin, and the inevitability that there will be public scrutiny of the results of the negotiations in the media as well as in Parliament, mark a major difference between pay negotiations in the Civil Service and in the private sector ... Experience suggests that public expenditure assumptions on Civil Service pay are more likely to reflect the view of the Government of the day on what is necessary to reduce inflation than the general trend of pay outside.
>
> 'The Government may therefore find itself placed in an awkward dilemma. If it attempts to stick rigidly to its pre-announced limits in the interests of its wider policy, this will amount to determining Civil Service pay by Government edict, a course which both we and the Government have rejected. Indeed, the Chancellor of the Exchequer made it clear to us in oral evidence that the Government as employer did not believe that it should seek year after year to pitch Civil Service settlements below market rates in the private sector.
>
> 'On the other hand, if the Government operates more flexibly it will have to do so in the full glare of publicity. Any relaxation of its original assumption may be presented as a weakness or as an example of the failure of the Government's wider policy.'

The Megaw Committee suggest three ways in which the 'danger of acute embarrassment or industrial conflict can best be avoided'.

1 'The Government should if possible avoid making explicit its assumptions about the impending Civil Service pay increases.
2 'The Government should as far as possible build realistic assumptions into its cash limits based on what is happening in the private sector.
3 'The Government should ... make clear that the cash limit system does not necessarily imply a rigid control of pay increases on the basis of the initial assumptions.'

We examined these proposals to see if our system could accommodate them.

We thought that the best way in which the Secretary of State could avoid making explicit assumptions about pay would be for the cash limit for the health service to be announced as a whole rather than being divided into pay and non-pay headings. The proportion to be spent on each would then be a matter for determination between the regional chairmen in their corporate role and the Secretary of State. These proportions would be agreed according to the priorities of the Secretary of State and the NHS.

So that the Government can build in realistic assumptions about likely levels of pay into its cash limits, we propose that the three pay bodies – The Doctors and Dentists Review Body, the Nurses and PSMs review body and our pay board – should issue their reports simultaneously. The review bodies would issue their recommendations with their reports; the pay board would issue its annual report, indicating where the middle range of earnings in the private sector lay, and consequently what would be the levels of increases around which the negotiators would be expected to bargain. In order to give the Cabinet sufficient time to take account of these figures in determining the cash limit for the following year, the pay bodies should report no later than September. There would, of course, be no reason for the government to indicate at that stage whether it was prepared to accept the recommendations of the review body.

We believe that the flexibility of bargaining around the inter-quartile, with possible trade-offs between levels of staffing, productivity agreements, other efficiency measures and service development in order for the staff side to obtain a higher figure, would demonstrate that the Secretary of State did not have a rigid control of pay increases.

OUR PROPOSED SYSTEM SUMMARISED

The system which we are proposing would look like this:

A pay board would be set up consisting of five members of management (including at least one representative of the department); five staff side members and an independent chairman appointed by the Secretary of State.

This board would agree the method of and type of comparitors to be used in collecting information about pay movements outside the NHS. The information would be collected by an independent agency, which is the same as used for the review bodies. (We believe that this ought to be the Office of Manpower Economics.) The management side representatives would have been briefed by the regional chairmen acting for the service and assisted by the pay information unit.

This initial exercise having been completed, the annual cycle of pay determination would be:

i) The pay board and review bodies issue their report on pay movements for NHS comparators by September.
ii) RHA chairmen, after consultations with district chairmen and officers and assisted by information from their pay research unit, discuss and agree priorities on pay and levels of service with the Secretary of State in the light of the figures issued by the pay bodies.
iii) Cash limits for the NHS are agreed by the Secretary of State and the Cabinet, taking into account the discussion in ii).
iv) The Secretary of State and the chairmen agree revised priorities in the light of the cash limit.
v) Whitley Councils, advised of these priorities, negotiate in each functional council.
vi) If there is no successful outcome of negotiation in any of the functional councils, the functional councils themselves decide to invoke the mediation/arbitration agreement.

We readily accept that there is no perfect system for determining pay in any industry or sector of the economy. We certainly do not claim that the system which is proposed in this paper is a total and instant solution to the problem of pay determination for the NHS. Pay systems, in the end, work because those who are party to them want them to work. We offer this contribution to the debate and discussion on the future of pay in the health service, because we believe that all the parties want to create a new system, and that there is a determination on all sides to make it work. We hope that this paper, written from the point of view of NHS management, will have some

influence on service thinking about the problem and that from discussion of it, a view will emerge which will be the view of the NHS. If this happens, we shall be content.

£1·25