Trade union recognition and the independent health care sector:

A literature review for the Royal College of Nursing

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Introduction

This literature review, which was commissioned by the Royal College of Nursing (RCN), considers the existing evidence about the benefits of trade union recognition in the workplace. Specifically, it focuses on the independent health care sector in the UK, or where that is not possible, on the wider voluntary and independent sector. Some of the statistics contained in this review relate to England only.

The review is largely based on literature published from 1997 onwards, when voluntary agreements began to emerge in anticipation of the introduction of a statutory recognition procedure. It also looks at subsequent literature evaluating the impact of that procedure, and the establishment of information and consultation bodies following 2004.

The review begins with an outline of the structure, regulation and prospects of the sector, focusing in particular on acute care, which is of particular interest to the RCN. This outline helps in determining the relevance of findings from other fields of care within the independent sector.

We have included recent literature that focuses on employment relations in the health sector, to examine the role of recognition in the development of effective employment relations. Because of a marked lack of data from the independent health sector in the UK, we have also included relevant evidence from the USA, Australia and Canada.

The review also explores literature dealing with the effect of employee relations strategies on staff satisfaction, turnover, sickness and absence rates, health and safety, pay, terms and conditions and other issues affecting an organisation. We have also explored employer assessments of the benefits of union recognition, where these are available.

Nick Clark
Senior Research Fellow
Working Lives Research Institute

Section 1: The independent health care sector

Sector value
According to National Statistics for UK Business for 2007 (quoted in the Keynote Market Report on private health care [Keynote, 2008]) there were 4,410 enterprises engaged in "Human Health Activities". Of these, only 105 (2.4 per cent) had a turnover of more than £5 million.

Department for Business Enterprise and Regulatory Reform (BERR) SME statistics for 2007 give higher figures: of 33,380 enterprises in human health, 22,340 (66.9 per cent) had fewer than 10 employees. 3.5 per cent of enterprises had more than 50 employees, of which 105 enterprises (0.3 per cent) had 250 or more employees. For comparison, in the overall economy, 83.6 per cent of employers have fewer than 10 employees, and 0.5 per cent have 250 or more staff (BERR, 2008). These statistics give a figure for total employment in the sector as 606,000, but although these figures cover the private sector (including public corporations and nationalised organisations), they exclude the not-for-profit sector.

The 2004 Workplace Employee Survey (WERS) included a sample of workplaces in "health and social work" (which accounted for 14 per cent of their total sample), of which 65 per cent were privately owned, with 16 per cent being described as "family-owned" (Kersley *et al,* 2006).

The Keynote Market Report also quoted estimates for market size of private health care from Laing's Healthcare Market Review, which gave the following breakdown for 2007:

Sector	*Value £m*
Long-term care	10,448
Acute Care	6,347
Psychiatric Care	3,942
Private Medical Insurance (PMI)	3,387
Primary care	648
Total	24,772

The total market was estimated to have increased by 8.1 per cent on 2006, and includes some NHS outsourcing within the acute care sector (14.5per cent in 2006), as well as substantial (over two-thirds) local government funding for care of the elderly and mentally ill (Keynote, 2008).

However, Keynote's assessment was that growth in private medical insurance (PMI) was "flat", and the market as a whole becoming more competitive. The growing use of the sector by the NHS, both for independent sector treatment centres and for elective surgery, is introducing closer scrutiny of costs. The PMI sector is also paying closer attention to costs. These observations by Keynote predate the current economic and financial crisis, which is likely to have intensified pressures on the sector.

Market leaders
In the acute care sector, there are 274 private hospitals in the UK, of which 48 are not-for-profit (Laing & Buisson figures, quoted in Johnston, 2008). The not-for-profit sector includes Nuffield Health, the Hospitals Management Trust, the London Clinic, and smaller single hospital operations such as the St John & St Elizabeth in London, and the Benenden in Kent.

The five main businesses are:

1. *Netcare* (formed in 2006 from General Healthcare Group, including BMI Healthcare hospitals, and Netcare UK). Said to account for 25per cent of independent sector acute care capacity, with 56 hospitals (including nine bought from Nuffield in 2008). Acquired by South Africa-based Network Healthcare Holdings in April 2006. Financed by a consortium including UK private equity investors.
2. *Nuffield Hospitals*. Registered as a charity. 33 hospitals, and acquired Cannons Health & Fitness in November 2007. In April 2009, sold Vanguard Healthcare (mobile operating theatres) to its management.
3. *Spire Healthcare Ltd*. 36 hospitals. Bought from BUPA (a provident association) by the Cinven private equity group in October 2007. In March 2008, Cinven also acquired Classic Hospitals Ltd.
4. *HCA International Ltd*. Six hospitals. US-based parent HCA Inc was bought by private equity investors at end of 2006.
5. *Ramsay Health Care UK Operations Ltd*. 31 hospitals. Ramsay Healthcare, based in Australia, purchased 30 hospitals from Capio AB in Sweden in November 2007, and the BMI Nottingham hospital in 2008.

Other significant providers in the sector are: Trustees of the London Clinic, Covenant Healthcare, Medical Services International, Hospitals Management Trust and Aspen Healthcare. (Keynote, 2008, Johnstone, 2008, Nuffield Health, 2007 and 2009, Charity Commission, Ramsay Healthcare).

As pointed out in the report *Directory of Social Change* on charitable status (Johnstone, 2008), the recent spate of takeovers means that for the first time, the largest proportion of the acute medical and surgery market outside the NHS is now accounted for by non-UK owned businesses.

Regulation and meeting standards
The sector is highly regulated, with national minimum standards set for all independent hospitals by the Department of Health in England. Since April 2009, the sector has been overseen by the newly established Care Quality Commission. As well as setting regulations on areas such as quality of treatment, complaints and premises and equipment, the Department of Health standards cover issues of particular interest to trade unions, notably human resource management and health and safety (DH, 2002). Considerable attention is devoted to the procedures for selecting staff and checking references, qualifications, registration and documents. However, the standards also include requirements for job descriptions, performance reviews, staff training, equal opportunities and anti-harassment and anti-bullying policies.

Some of the industry, at least, is clearly finding it difficult to meet the required standards. Inspections in England during 2007-8, for example, found that of 190 establishments assessed against Core Standard C9 *("There is a written human resources policy and supporting procedures, in line with current employment legislation"*), only 84 (44 per cent)

fully met the required standard, while a further 73 (38) “almost met” it, and 31 (16 per cent) did not meet the standard (Healthcare Commission, 2008).

Far fewer establishments were assessed on the Health and Safety Standard A9 (which applies to acute hospitals), but of 19 assessed, four did not meet, and one “almost met” the standard, which states:

> *“An annual health and safety report is produced by the hospital. The report summarises the actions taken to ensure a safe, healthy environment, including, for example, training given to staff, risk assessments undertaken and action taken as a result, and an outline plan for health and safety actions to be implemented in the year ahead*.” (DH, 2002).

If these findings are representative of the acute hospital sector as a whole (and it is too small a sample to be certain), it would mean that 20 per cent of independent hospitals in England would fail this basic test of Health and Safety good practice.

A significant number of the independent hospitals in England – 100 as at January 2009 – have signed up to offer NHS patients treatment under the Extended Choice Network (ECN). These are subject to further regulations under rules applying to the agreement to provide such services, including for example the need to conduct Equality Impact Assessments (DH, 2009).

A minority of independent hospitals in England (17.5 per cent) are operated on a not-for profit basis. This means that they are also subject to “public benefit” tests in the Charities Act of 2006. This is likely to present a challenge, according to the *Directory of Social Change* (Johnstone, 2008): “Independent not-for-profit hospitals with charitable status have the dual task of existing to carry out charitable purposes and of competing in the highly competitive market with for-profit providers.” The author considered it “debatable” whether such organisations could pass the public benefit test. In an examination of the accounts of Nuffield Health and the London Clinic, she points out that while both organisations claim to offer subsidised or free places to low-income patients, they did not demonstrate the extent to which this was implemented in practice.

The list of facilities offering ECN and FCN (Free Choice Network) services includes 19 hospitals operating on a not-for-profit basis, suggesting that all of the regulations described above would apply to them (DH, 2009a).

Section 2: Trade union recognition

Background

A legal definition of trade union recognition is set out in Section 178 of the Trade Unions and Labour Relations (Consolidation) Act 1992:

" 'Recognition', in relation to a trade union, means the recognition of the union by an employer, or two or more associated employers, to any extent, for the purpose of collective bargaining." (TULR(C)A 1992 s. 178(3)).

This is the test for determining if a union is entitled to certain other statutory rights – consultation over redundancies, transfers, contracting out from the second state pension, and health and safety, and time off rights for representatives. The Act also sets out a list of topics considered to be "collective bargaining" if they are subject to negotiations between union(s) and employer(s):

"a) terms and conditions of employment, or the physical conditions in which any workers are required to work;
(b) engagement or non-engagement, or termination or suspension of employment or the duties of employment, of one or more workers;
(c) allocation of work or the duties of employment between workers or groups of workers;
(d) matters of discipline;
(e) a worker's membership or non-membership of a trade union;
(f) facilities for officials of trade unions; and
(g) machinery for negotiation or consultation, and other procedures, relating to any of the above matters, including the recognition by employers or employers' associations of the right of a trade union to represent workers in such negotiation or consultation or in the carrying out of such procedures." (TULR(C)A 1992 s. 178(2)).

The later Employment Relations Act 1999 (ERA, 1999) adds further, but more restrictive, detail to statutory – as distinct from voluntary – recognition (see *New recognition rights*, below). But for voluntary agreements, only one of the topics *a – g* above needs to be negotiated to qualify as recognition, and there is no requirement for a written collective bargaining agreement. So, as pointed out in a study of 15 cases of de-recognition (Brown *et al,* 2001), the distinction between recognition or non-recognition can be blurred: "Bargaining at the level of the enterprise does not necessarily proceed on the basis of formally defined recognition rights". Indeed, a union may have "little more than the specification of its role in a grievance or discipline procedure," or a role in consultation procedures.

In most studies referred to in this review, (for example, Kersley *et al,* 2006), recognition is defined as granting some collective bargaining rights, usually over pay and/or other conditions of employment.

New recognition rights under New Labour

The 1980s and '90s were decades of decline in trade union membership and collective bargaining coverage. In 1980, 64 per cent of workplaces had at least one union recognised for collective bargaining, but by 1998 this had fallen to 42 per cent (Machin, 2003).

Unions lobbied for statutory rights on recognition, and the Labour Government elected in 1997 proposed new rights in a 1999 white paper, *Fairness at Work*. These rights were

enacted in the Employment Relations Act 1999 (ERA, 1999). The Government explained its aims for the recognition provisions as:

"promot(ing) a flexible labour market in which organisations and individuals are able to adapt to changing economic and personal circumstances - which requires an underpinning of decent minimum standards so that changes in the workplace can be based on trust and co-operation." (DTI, 1999).

It is not the purpose of this review to analyse these provisions in detail. In outline, they provided a procedure whereby a union, if it could demonstrate the required levels of membership or support, had the right to be recognised for bargaining in identified bargaining units where there were more than 20 employees. However, the procedures, beginning with an application to the Central Arbitration Committee (CAC), were designed to encourage voluntary agreements in preference to those enforced by statutory means. Statutory recognition would be granted where a union or unions could demonstrate more than 50 per cent membership in the designated bargaining unit, or where the union(s) had less than 50 per cent but more than 10 per cent membership and they could win a majority in favour of recognition in a supervised ballot. Statutory recognition provides the right to bargain over pay, hours and holidays, whereas there is no restriction on what can be included in voluntary agreements concluded before or during the CAC processes.

The ERA 1999 also introduced the right for individuals to be represented, including by their union, in serious grievance or disciplinary matters.

However in 2002, the European Court of Human Rights, in the *Wilson and Palmer* cases, judged that a worker's right to freedom of association was still inadequately protected (Thompsons, 2002). The 2004 Employment Relations Act (ERA, 2004) therefore introduced further protections against detriment for members seeking the support of their union. Despite this, the law still does not fully protect collective rights, and one view describes statutory recognition as: "a diversion for trade unions. It enshrines their illegitimacy". (Smith and Morton, 2006). These writers were critical in particular of a trend towards employer advantage, both in traditional collective bargaining and within "partnership" arrangements (see *Management attitudes*, page xx).

Following the introduction of the EU Directive on Information and Consultation, further representation rights were introduced in the UK under The Information and Consultation of Employees Regulations 2004 (TICER). These required the establishment, at the initiative of management or by request of employees, of bodies to permit employees to be informed and consulted over issues relating to business and employment issues and restructuring. It applied from 2005 to undertakings with at least 150 workers, the threshold reducing to 50 by April 2008.

Extent of recognition

The most comprehensive source of data on trade union recognition is the Workplace Employment Relations Survey (WERS). The 2004 WERS reported that managers said they recognised at least one union[1] in 30 per cent of all workplaces. This recognition was more likely to be reported in larger workplaces, so that 30 per cent of workplaces represented 50 per cent of the workforce covered by the survey. In about half of those workplaces recognising unions (49 per cent), recognition was granted to a single union.

[1] For the purposes of negotiating the pay and conditions of any sections of their workforce.

Amongst the balance, where more than one union was recognised, there was “single table bargaining” in 60 per cent of cases (Kersley *et al,* 2006).

Recognition is far more common in the public than the private sector – 90 per cent of public sector workplaces reported recognition in 2004, compared with 16 per cent in the private sector. This represented a decline from the 1998 WERS, with the largest change being seen in the private sector. Nevertheless, even in the private sector, the majority of workplaces with 200 or more employees still had recognition of at least one trade union.

However, in smaller workplaces (10-24 workers), the change was most marked. The rate of recognition fell from 28 per cent of all workplaces in 1998 to 18 per cent in 2004. By contrast, the shift was less significant among workplaces with 25 or more workers – from 41 per cent to 39 per cent.

This overall slowing of decline in recognition represented a change in the trend, previously detected in data from the 1980s and 1990s (Milward *et al,* 2000), which showed an average decline in the rate of recognition in those larger private workplaces of only 3-4 per cent per annum.

It is possible that the slowing of decline in recognition in larger workplaces is due in part to the rights gained by unions from the ERA1999. The number of claims for recognition submitted to the Central Arbitration Committee for 1999 to 2004 was 455 - fewer than had originally been anticipated. Of these, 272 were accepted (many having been withdrawn), but only 52 awards of automatic recognition were made, with a further 72 cases where ballots on recognition were won. Voluntary agreements were reached in a further 85 cases, before CAC procedures had been completed (Gall, 2005b).

Achieving recognition on this scale could not, on its own, explain the change in rate of decline. It represents only part of the picture. A comprehensive study based on a variety of survey, official and trade union sources showed that most unions had stepped up their activities concerning seeking new recognition agreements. Data from both the TUC and ACAS shows a marked increase in the number of new recognitions in the years immediately following the passing of the ERA 1999 (Wood *et al,* 2003). The TUC, for example, reported 75 new agreements between December 1998 and October 1999, 149 from November 1999 to October 2000, and 443 between November 2000 and October 2001. The authors concluded that this suggested that the existence of the statutory procedures acted as a stimulus to voluntary agreements, at least in the early years of the legislation.

The information and consultation bodies provided for by the TICE Regulations do not appear to be very widespread. WERS covers a period before the regulations came into force, so does not reflect any change related to the Regulations. The Involvement and Participation Association reported CIPD data suggesting that fewer than 40 per cent of managers had done anything to implement the regulations (Coupar, 2009), and from case studies, the structures often appear to be working alongside recognised unions, rather than instead of them (Hall *et al,* 2008).

Nature of recognition

Recognition, while closely associated with collective bargaining, may not always lead to it. In the 2004 WERS, 86 per cent of workplaces with at least one recognised trade union reported some collective bargaining (Kersley *et al,* 2006), suggesting that one in seven recognised union(s) but did not negotiate with them.

An analysis of 213 voluntary recognitions concluded between 1998 and 2002 (Moore *et al,* 2004) found that nine per cent of agreements were limited to consultation or collective representation and did not extend to collective bargaining. Amongst the majority which did include bargaining, 20 per cent mirrored the statutory provisions of the 1999 ERA by specifying three core issues: pay, hours and holidays. While a few (five) restricted bargaining to less than those core issues, most (56 per cent) defined the areas to be covered by bargaining in general terms such as "pay and conditions" or "terms and conditions". However coverage may have been expressed in the text of recognition agreements, amongst those agreements providing for bargaining, the majority (69 per cent) included specific reference to pay, 45 per cent to hours and 37 per cent to holidays. Moore *et al* pointed out that bargaining on pay remained central in the new recognition deals, but also referred to constraints on the capacity of some managers to negotiate over pay because resources were restricted by parent companies. Limits on the ability to negotiate over pay have also been identified as a constraint on organising in those sections of the voluntary sector where public sector contracts set rigid cost limits (Cunningham, 2008).

Moore *et al* (2004) also examined the extent to which specific non-core issues were referred to in agreements - pensions, training, equal opportunities, sick pay, redundancy and family-friendly policies. These are set out below.

14. Bargaining on non-core issues – pensions, training and equal opportunities

Reference to issues	Pensions (%)	Training (%)	Equal opportunities (%)
Specifically included	14 (8.0)	12 (6.9)	14 (8.0)
Specifically excluded	54 (30.9)	54 (30.9)	54 (30.9)
Terms and conditions	99 (56.6)	100 (57.1)	99 (56.6)
Unspecified	8 (4.6)	9 (5.1)	8 (4.6)
Total	175 (100.0)	175 (100.0)	175 (100.0)

Source: TUC/LRD database of voluntary union recognition agreements (2003) *Documented agreements, with provision for workplace or employer-level negotiations, retrieved from 253 survey responses

15. Bargaining on non-core issues – sick pay, redundancy, family-friendly

Reference to issues	Sick pay (%)	Redundancy (%)	Family-friendly (%)
Specifically included	20 (11.4)	16 (9.1)	12 (6.9)
Specifically excluded	44 (25.1)	48 (27.4)	49 (28.0)
Terms and conditions	103 (58.9)	103 (58.9)	106 (60.6)
Unspecified	8 (4.6)	8 (4.6)	8 (4.6)
Total	175 (100.0)	175 (100.0)	175 (100.0)

Source: TUC/LRD database of voluntary union recognition agreements (2003) *Documented agreements, with provision for workplace or employer-level negotiations, retrieved from 253 survey responses

From Moore S, McKay S and Bewley H (2004) *The content of new voluntary trade union recognition agreements 1998-2002: Volume 1- an analysis of new agreements and case studies.*

In all cases, the additional topics were more likely to be excluded than included in the text of the agreements. But most commonly, there was no specific mention of them within the agreement, leaving it open to the parties to consider these matters under the more general heading of “terms and conditions”. From a further nine case studies conducted as part of the same analysis, it seems that this was in fact the case. For example, in four of these case studies, negotiations had taken place over sick pay, even though this was not specified in the text of their recognition agreements.

A follow up telephone survey of 101 employer representatives, conducted between July and September 2004, found that in the majority of cases there had been discussions with union(s), not only on pay, hours and holidays, but on training, redundancy, sick pay and equal opportunities too (Moore, 2006). Only in the case of pensions did the majority of employer representatives say that there had been no discussions.

However, when employer representatives were asked to categorise the form discussions had taken (negotiation, consultation, information or determined at national/industry level), only pay hours and holidays were said by a majority to have been negotiated. In the case of sick pay, 46 per cent of those reporting discussions said it was negotiated locally or dealt with at the national level, compared with 32 per cent reporting consultation and 22 per cent information. The other issues (training, redundancy, etc) were most likely to be the subject of consultation.

So even identically worded agreements will operate differently in differing circumstances, and in some cases unions will conduct *de facto* negotiations with management even where no formally acknowledged procedure for doing so exists. In others, the commitment to negotiations written into the agreement may not be implemented, with management preferring (and unions perhaps accepting) consultation.

Section 3: Trade union recognition in independent health care

The WERS sample provides some useful insights into the structure of worker representation and collective bargaining within the sector (Kersley *et al,* 2006). Of 439 workplaces in the "health and social work" sector approached by the survey, 65 per cent responded - 288 workplaces. Of these, 65 per cent were private sector organisations.

Forty one per cent of all workplaces in the health and social work sector overall were reported to have trade union recognition, but this fell to only 16 per cent for those in the private sector. This was the average level of recognition for the whole private sector.

However, the survey reports recognition in workplaces accounting for only 23 per cent of the workforce in the sector, compared with 33 per cent in the private sector as a whole. This suggests that recognition was less prevalent in larger workplaces in private health and social work than it was in large workplaces in the rest of the private sector. This may be related to contracting-out of care services from local government, where recognition has continued as a result of the Transfer of Undertakings (Protection of Employment) Regulations (TUPE). This is likely to have happened in medium-sized undertakings, while the larger workplaces in this sector are independent hospitals which have traditionally been, for the most part, non-unionised.

Thirty-six per cent of all workplaces in the sector reported collective bargaining, so of the 41 per cent of workplaces with recognition, in five percent, or one in eight, it did not result in formal negotiations over pay and conditions.

Representation arrangements not involving union recognition do not appear to be widespread. The WERS data showed that 49 per cent of workplaces had some form of representation, and this included the 41 per cent who had recognition. The comparable figure from WERS 1998 was 66 per cent, indicating a substantial decline in any form of employee representation in the sector.

Kersley *et al* do not break this down further to permit comparison between the public and private sectors in health and social work. It is beyond the scope of this review to examine the WERS data on the sector in further detail. However, the WERS sample is of sufficient size to permit further meaningful research should the need arise in future.

A 2005 survey of RCN members suggested that the decline in representation in the private sector is most significant. It showed that the level of consultation with nurses over work/life balance issues or facilities (such as catering or changing rooms) was lower in 2005 than in 2000, and was dropping fastest in the independent sector – to the extent that the relative positive balance in favour of independent sector over NHS found in 2000 was all but gone by 2005. So for example, while 26 per cent of NHS nurses reported being consulted over work/life issues in 2000, this had dropped to 18 per cent in 2005. The corresponding figures for independent hospital nurses were 38 per cent (in 2000) down to 18 per cent (in 2005) (Ball *et al,* 2006).

Much of the published work on employee relations in health care relates to North America, the USA in particular. This is also true of data regarding union representation. A study published in 1987 linked the extent and prospect of collective bargaining in US hospitals to a number of factors which are of interest: the complexity of the hospitals, the supply of qualified staff, and the regulatory environment (Alexander and Bloom 1987). The authors concluded that the likelihood of bargaining would increase when labour supply was short

(because this would mean that there was potential to raise wages), when hospitals carried out a wider variety of activities (increasing the prospects of conflict), and when the regulation of the hospitals was intensified. However, the principal focus of this study was on bargaining over pay, and it may be that for the workers in the sector we are examining, other matters take precedence over this.

More recently, there have been major recruitment drives among a number of competing US unions aimed at health care workers (Hospitals and Health Networks, 2007). This is seen as a response to intensified pressure on staff as employers attempt to pass on to the workforce the consequence of insurers' curbs in costs (Evans, 2008). This resulted in a reported 10.4 per cent increase in union membership amongst health care professionals during 2007 alone.

Within the UK voluntary sector, a survey of 143 employers (26 of which were classified as being in health), found that 31 per cent recognised unions (Cunningham, 2001). This survey reported an increase in union activity, particularly aimed at securing recognition, partly in response to the ERA 1999. Simms (2007) suggests another (not contradictory) explanation. She cites evidence that human resources (HR) practice in the voluntary sector is moving closer to that in the "for profit" sector, and that this is accompanied by unions paying more attention to organising in the voluntary sector. She also points out that in this sector, an employer's stated core values may be unfavourably contrasted with their employees' experience of the employer's behaviour in practice.

Section 4: Benefits and consequences of recognition

Management attitudes

Partly because of the decline in formal collective bargaining with trade unions, partly because of the growth of other forms of representation (such as European Works Councils (EWCs) and Information and Consultation bodies), and partly because there has been a growth in attention to human resource management methods, much more recent research on employee relations is devoted to "employee voice" rather than solely to union presence or recognition. In a detailed examination, however, Marchington *et al* (2001) argue that the precise meaning of the term "recognition" is open to question, and that the choice of methods of negotiation with staff will be determined in line with a number of considerations – including moral or economic ones, as well as the question of managerial culture.

Bryson *et al* (2004) examine the considerations that such choice involves for management, and concludes that: "Employers will buy union voice where on grounds of cost, quality and risk it is worth it". Examining the data from WERS, the authors suggest that the decline in union recognition as the sole channel for "voice" may be related to the capacity of unions to deliver "quality" of voice - that is to say, unions' capacity to be genuinely representative. High quality of voice is seen by the authors to be more likely where the rate of union membership is high, although this would also require union representatives to be in close touch with members.

Interestingly, Bryson *et al* suggest that experience of EWCs and joint consultative councils increases employer support for unionisation. This was supported by findings based on a series of structured interviews with senior HR and personnel staff in 11 companies which had, or were contemplating, partnership agreements/arrangements with unions (Oxenbridge & Brown, 2002). Some were production/manufacturing enterprises, but the majority were in private services The managers reported that: "union involvement in communication, pay-setting and consultation processes led to greater effectiveness and less management effort".

Union gains from these partnerships were reported to be that employers encouraged workers to become members, and that pay and conditions were better. However, the content of recognition agreements in these companies was limited. Pay bargaining was restricted, and four out of the eleven did not bargain over other terms and conditions either. Although training and health and safety were included in all agreements, in the majority of cases this meant consultation, rather than negotiation.

Managers in the Oxenbridge and Brown study cited union assistance in managing change as the main reason for wanting co-operative relationships, specifying consultation, redundancy and redeployment as key issues. Service company managers saw as valuable the unions' facilitation in harmonising disparate terms and conditions arising from mergers, acquisitions and tendering.

A series of case studies across various sectors (Dundon *et al*, 2004) found that those employers recognising unions "regarded them as a positive force in expressing employee concerns". Moore *et al* (2004) in their study of new recognition agreements also found that employers valued mechanisms which permitted workers to "have their say". Managers were more cautious about whether or not this had led to improved industrial relations than were union representatives, but nevertheless saw benefit in having more formal employee representation.

In a survey of voluntary sector employers in Scotland, Jackson *et al* (2001) found that management were not concerned over the new rights conferred on unions by the ERA 1999. They suggested that this may in part have reflect those managers' positive experiences of unions' role in representing individual members. In one case, the senior manager would have positively welcomed union involvement as a means of dealing collectively with proposed changes to terms and conditions. However, in some cases, HR managers had doubts about how other members of their management teams would respond to unions.

Using data from the 1998 WERS, Bryson sought to evaluate the effect of trade unions on the perceptions of employee relations from the point of view of both employers and employees (Bryson, 2005). He found that, from management's point of view, there was a "lubricating effect" which assisted with employee relations, but that this depended on having locally-based lay representatives (particularly those who were able to work full-time on union duties). The contrary finding was that where the union was able to extract a significant wage advantage, it was more likely that employees (rather than their managers) regarded relations with management as poor. He suggested that this could reflect that unions who were achieving higher wages were adopting an adversarial approach, which fed into union members' poor perceptions of the relationship.

In the late 1990s, the idea that such antagonistic relations could be replaced by a more co-operative approach, identified as "partnership", began to be promoted, particularly by the TUC and New Labour Government. Badigannavar and Kelly (2004) give a brief outline of the concepts as promoted variously by the TUC, CiPD and IPA, before going on to evaluate their supposed implementation in four public sector organisations, including two NHS trusts. They considered the six principles of partnership as advocated by the TUC: focus on the quality of working life, commitment to job security, transparency in management, recognition that there legitimate different interests of the parties, a shared commitment to success of the enterprise, and mutual gains. The authors concluded that there was little evidence to show that any gains had been mutual, or that the "voice" delivered by partnership was better for the workforce.

In the USA, one prominent partnership was formed between a consortium of unions and health care provider Kaiser Permanente (KP). One of the key points of interest in establishing this partnership appears to have been getting a large group of unions to co-operate in the agreement, rather than evaluating its outcome for patient care and workforce interests. However, a detailed study of the partnership from 2002-4 (Kochan *et al,* 2005), while regretting the absence of means to evaluate all factors, was able to point to a substantial fall in grievance rates, from about 15 per 1,000 employees in 1998 to 7 per 1,000 in 2002. Involvement in the partnership also brought with it a better understanding of the organisation, agreement with its goals, and belief that workers could influence decisions. Although the researchers were not able to test whether such improvements were contributing to better patient care by KP, they pointed to other studies of service industries which showed the positive relationship between employee satisfaction and customer satisfaction.

Dietz *et al* (2005) concluded that if partnership were to be considered as a relationship between management and workforce (rather than management and a union), there would be no reason why it could not be present in non-union employers. However, they tested this hypothesis with only one case study, a medium sized employer with a committed managing director and substantial employee share holding, although they did refer to other research to support their view.

Conversely, a case study of a retail employer which had set up a staff council in the 1970s concluded that "voice" that is controlled by management is likely to prove ineffective. There was widespread disillusion with the staff council by employees - although this did not lead to any corresponding enthusiasm amongst staff for representation through a trade union (Badigannavar and Kelly, 2005).

Pay

In the United States, the existence of a union wage premium is accepted, and relatively easily demonstrated. Figures for 2005, taking into account both wages and benefits (such as pensions and health insurance), showed an advantage of over $10 per hour, or 43.7 per cent (Yates, 2009). Yates also shows that the level of advantage is greater for groups who tended to suffer greater disadvantage in the workforce, such as ethnic minorities. Specifically in health care, US Federal Bureau of Labor Statistics figures showed that in 2007, the union wage premium for professional and technical workers (which includes nurses) was 11 per cent (Evans, 2008).

Analysis of statistics for Britain is not so widely available, and the demonstrated wage difference smaller. Blanchflower and Bryson (2004) produced figures for 2000 showing, according to the Labour Force Survey and British Attitudes Survey, union wage differentials of 10.3 per cent and 5 per cent respectively. However, after adjusting for occupation and workplace size, they concluded that there were: "real questions as to whether there is a significant union wage premium for workers in the UK". David Metcalf (2004) also looked at the issue and calculated the overall premium as 6 per cent, but with women, manual workers and those in non-manufacturing parts of the economy benefiting more, while for men the effect appeared to be negative.

An earlier study (Metcalf *et al*, 2001).shows the union effect on another aspect of pay – that of fairness. Examining data from 1998, the authors showed that as a result of greater use of objective criteria for setting pay (such as job classification or length of service), unionised workplaces had a narrower spread of pay. This occurred in particular as a result of raising the lowest rates and narrowing differentials between men and women and between black and ethnic minority workers and white workers.

Traditionally, workers covered by collective bargaining get better pay and conditions. This is difficult to test in UK health care, which is heavily skewed towards NHS. In the USA, however, Hirsch and Schumacher (1998) concluded that while there were union wage premiums, they were lower in health care than for workers employed in other sectors. Within the health care industry, the premium was lower for registered nurses than for other, lower skilled workers. The authors suggested that this was because in general, employers recognising unions could pick workers likely to perform better than required in lower skilled jobs, because of competition for "union jobs". In nursing, however, which was already highly regulated and the required skills clearly set out, the potential for a differential based on such "unmeasured skill" was lower.

Sources quoted by Frijters *et al* (2003) conclude (based largely on experience outside the UK, in particular the US), that the supply of qualified nurses was not particularly responsive to the level of wages. This is taken to mean that other factors such as workloads, overtime, training, prospects of promotion and shift-work are more significant in decisions to stay working in public health. However, Frijters *et al* cited British research suggesting that the size of the private nursing sector and comparative levels of pay in the locality were also important determinants in decisions to leave NHS nursing (Gray and

Phillips 1996, Shields and Ward, 2001). Their own research was based on data from the panel survey within the Labour Force Survey (LFS), and examined the responses of 6,971 nurses from spring 1997 to winter 2001. Seventy eight per cent of these were in the NHS, 15 per cent in private sector nursing, 3 per cent in other public sector employment and 3 per cent not working. They identified 479 nurses who had left the NHS (they did not analyse changes in jobs of those in the private sector) during the period, of whom 21 per cent went into private sector nursing, 7 per cent elsewhere in the private sector, 35 per cent elsewhere in the public sector and 37 per cent into non-participation.

Although this sample was not large enough to permit analysis by destination sector, Frijters *et al* concluded that, amongst those in work, the hourly wage commanded by nurses having left the NHS was 19.7 per cent lower than it would have been had they stayed. These nurses also appeared to work longer hours – by 1.5 hours per week on average. However, the study also noted "a general movement towards non-shift work" (the authors did not enumerate this). The authors concluded that issues other than pay and length of the working week were key in determining departure from the NHS. In the absence of research specifically aimed at the UK independent sector, it seems reasonable to conclude that an issue such as non-shift working may be of greater significance to the independent health care workforce than pay.

Holidays

Paid annual holiday entitlement is a core subject for collective bargaining, but there is surprisingly little data identifying the gains made by trade unions in this sphere. In a paper pre-dating the UK implementation of the EU Working Time Directive, Green (1997) showed that unionised workers were 11 per cent more likely to have any paid holidays than their non-union counterparts, and that for those with holidays, annual entitlement was 5.5 days longer per year in workplaces with recognition than in those without. The introduction of the Working Time Regulations in 1998 brought for the first time a minimum entitlement for annual leave (initially for 15, and then 20 days per year).

Although this significantly reduced the number of workers having no paid holidays (when the Regulations were introduced, 8 per cent of the workforce stood to benefit), it still left some workers with less than their entitlement. A BMRB survey conducted in 2001 found that those who reported getting less than 20 days were half as likely to be trade union members as the workforce as a whole (DTI, 2004). A later analysis of LFS data, but again before the Working Time Regulations, found a union advantage of 1.6 days on average (Bryan, 2006).

Retention of staff

Staff turnover amongst trade union members is generally found to be lower than amongst non-members, but expressed dissatisfaction at work higher. Freeman and Medoff (1984) proposed an explanation to this seeming paradox - the "exit-voice trade off". They suggested that by regulating workplaces and improving pay and conditions, unions made staying in the job more attractive, but that by offering members a chance to make their views known ("voice") they also encouraged the expression of discontent, and that this was in itself a valuable benefit as it could be an alternative to simply quitting. However, the rate of turnover was also affected by the existence of seniority provisions, common in US collective agreements, which give longer-serving staff special privileges (a degree of protection from layoffs, for example).

Freeman and Medoff's hypothesis was tested more recently in the USA, using 2001 data collected as part of the Harris Poll employee satisfaction survey (Abraham *et al*, 2005).

The authors concluded that though they could not categorically rule out the possibility that better pay and conditions could explain lower turnover amongst union members, they had demonstrated that: “unions provide employees with collective voice in the workplace that will reduce employees’ intent to leave”.

An earlier attempt to test this hypothesis in the British context, however, came to different conclusions (Bender and Sloane, 1998). Using data gathered in the Social Change and Economic Life Initiative Survey (SCELI) during 1986 and 1987, the authors sought to examine the causes of dissatisfaction, in order to establish whether it was genuine or simply “voiced”. They concluded that the dissatisfaction was genuine and related to poor industrial relations, and speculated that this could be the result of collective bargaining. It could also be argued, however, that collective bargaining was the result of workers becoming organised in response to poor employee relations. Moreover, the findings did not challenge the tendency of trade union membership (which can generally be taken as an indicator of trade union recognition in the workplace) to reduce staff turnover. However, Gall (2005a) suggests that workplaces with high turnover may be harder to organise, which may result in a tendency for workplaces where turnover is lower to be better represented amongst those with union recognition.

A later study based on interviews with managers in 18 British organisations (across a number of sectors, including services and not-for-profit) concluded that turnover and absence statistics were not maintained systematically enough to make valid comparisons of the effect on these statistics of “employee voice” (including trade union recognition and consultation) (Dundon *et al* 2004). Any assessment of their effect therefore, the authors concluded, depended on management impressions. However, managers tended to link employee voice with lowering of staff absence and turnover rates, as part of a more general improvement in attitudes.

From an examination of the 2004 WERS data, Moore *et al* (2008) found that where there were union representatives (rather than non-union ones), the incidence of serious disciplinary sanctions was lower. They argued that this demonstrated that the union had a restraining effect on management prerogatives. This could then result in lower dismissal rates.

Turnover is clearly an issue in health care. The 2004 WERS data showed that in health and social work, labour turnover was 17 per cent (compared to 20 per cent for all workplaces), but that 30 per cent of workplaces reported annual turnover of 25 per cent or more (the same proportion as the overall sample) (Kersley *at al* 2006). This includes the public sector, and Kersley *et al* provided no separate analysis for private sector workplaces in health and social work. They did, however, point out that turnover across all public sector workplaces was 9 per cent, compared to 35 per cent for all private workplaces.

It is not clear that this difference would be reflected in nurses in the public and private sectors. A study of over 8,000 NHS nurses in England and Scotland conducted in 1999 reported that about one in three were planning to leave their current post in the next 12 months (Sheward *at al,* 2005).

Specifically considering health care, in this case, care of the elderly, Chou *et al* (2002) suggested that staff turnover can be reduced and patient care improved by increasing staff satisfaction, and that this can be achieved by improving “professional support” . Although the presence or absence of trade unions was not taken into account, providing training and

holding regular staff meetings were proposed as measures likely to strengthen professional support.

Sickness absence

According to the 2004 WERS data, the existence of sick pay arrangements which go beyond the legal requirement (Statutory Sick Pay) is linked to collective bargaining. In workplaces with no collective bargaining, only 45 per cent had "extra–statutory sick pay", but amongst those with any collective bargaining, the figure was 79 per cent (Kersley *et al,* 2006). This suggests that unions are able to secure better arrangements for their members who fall ill, and is supported by the data cited above on the frequency with which sick pay is the subject of negotiation (Moore, 2006).

Kersley *et al* found no apparent causal link between payment of extra-statutory sick pay and the level of sickness absence, in fact such workplaces had slightly lower levels of absence. The health and social work sector had a higher average of absence than across all workplaces – 6.4 per cent working days, compared to 5.0 per cent overall. The public sector, with a higher rate of unionisation, has a higher rate of absence than the private, but the claim sometimes made in the media that trade union members have a higher rate of absence does not seem to be supported by evidence from the UK, once sectoral differences are accounted for.

However, most sickness absence seems to be of a medium - to long-term nature. Cunningham (2000) cited LFS statistics for 1987-1991 to suggest that the majority of time lost to sickness absence was for more than 6 days: 42 per cent of spells of absence were for more than that period, with 32 per cent being for more than two weeks. He went on to argue that this suggested that rather than instituting punitive controls on short-term absences, a focus on return-to-work strategies would have more influence on levels of absence.

In a survey of 77 HR professionals, Cunnningham found that those recognising unions were more likely to have written return-to-work policies. These, in turn were more likely to result in use of adjustment of hours, transfer of employees to other work, lighter duties, working from home and counselling. Organisations using these strategies saw a steeper decline in absence rates than those not having such policies. Trade unions were closely involved, with 62 per cent saying that the policy had been introduced with union agreement, and 80 per cent saying that union representatives were involved in supporting "the return to work of employees who were fit to work but unable to carry out full duties".

This is clearly of relevance in the independent health sector. In a survey of members conducted in 2000, the RCN found that only a minority of members (36 per cent) said that their employer helped them to get treatment enabling a return to work after illness. The problem was worst in the independent sector, with only 13 per cent of those in nursing homes reporting the availability of assistance (RCN, 2002).

Commitment

Within the voluntary sector, it is often claimed that staff have a distinctive culture relating to the values or aims of the organisation, which causes them to have a high level of commitment. Cunningham (2001) cites a number of references supporting this view, including the 1998-99 UK Voluntary Sector Statistical Almanac. However, he suggests that recent changes in the sector's relationship with the state, both as customer and regulator, may make such assumptions inaccurate (if they were ever true). Simms (2007) points out that the divergence between employers' stated values, and those they exhibit towards their

staff, can increase the propensity to organise. Kochan *et al* (2005) show an increase in measures showing staff commitment, correlated to participation in union/management partnership at the US provider Kaiser Permanente.

Training

Cunningham (2001) found that 30 per cent of voluntary sector employers reported being required to introduce best practice in training by their funding bodies. In their 2006 paper on union learning, Warhurst *et al* cite several sources, including the 2003 Labour Force Survey, as demonstrating that unionised workplaces are more likely to offer training. Their detailed examination of three case studies (including an NHS trust) concluded that union-led learning provided employees with additional learning and training which would not otherwise have been present (Warhurst *et al,* 2006).

Dealing with change

The importance of employee voice comes to the fore when there are significant changes to be implemented at the workplace. Of these changes, redundancies in particular require consultation with the workforce, as a result of implementation of the EU Collective Redundancies Directive (98/59/EC). Nevertheless, this does not always take place – WERS 2004 showed that in 23 per cent of workplaces where redundancies had occurred, there was no consultation. However, where there was at least one recognised union, this proportion fell to 14 per cent (Kersley *et al,* 2006). Consultation was not only more likely with union representatives (in 18 per cent of all workplaces, but 55 per cent of those with a recognised union), but also with joint consultative committees or similar structures (14 per cent of all workplaces, but 29 per cent of those with unions).

The involvement of unions in change may be specific - the analysis of voluntary recognition agreements conducted by Moore *et al* (2004) found that some provision for dealing with organisational change occurred in 38 per cent of agreements.

But even where other structures exist, unions may prove preferable. An examination of information and consultation (I&C) bodies during 2006 showed that when it came to dealing with organisational change, managers would deal with recognised unions, by-passing the consultative structures. As the authors noted, “these bodies have no external source of strength or advice. They are unusually dependent on management” (Hall *et al,* 2008). This reflects the points made earlier in our review about the need for quality in mechanisms for putting forward workers’ voice.

A study of three NHS trusts (Bach, 2004) showed that under pressure from Government initiatives, HR departments tended to develop strategies aimed at responding to the “audit culture”, such as staff surveys, driving down absence and establishing the policies required by Government. Though HR managers saw unions as an important part of implementing change, this was more as part of the management process than as representatives of employee views. Direct communication with staff was stepped up but this did not, for the most part, appear to reassure staff, and was not matched by an improvement in emplolyees’ opportunity to be heard. In the case of nurses, however, directors of nursing drove approaches which led to staff involvement in professional issues, which offered the greatest scope for real participation.

Clark *et al* (2001) examined the effect of market-based reforms in US health care delivery on the propensity of nurses to opt for union representation. In a period of substantial structural change, the authors sought to evaluate whether mergers and job restructuring were related to nurses’ perceptions of the quality of patient care, whether this influenced

their likelihood of voting for the union, and whether this in turn was related to "union instrumentality" – the extent to which the nurses perceived that a union would be able to deal with their concerns. In their analysis of 519 questionnaire responses from nurses in Penn State, the authors found that nurses had a more negative view of patient care if they had experienced job restructuring. If they perceived problems with administrative support and their opportunity to exercise "voice", they were more likely to favour union representation. Overall, the research showed that an individual's perception of a union's ability to bring about desired change (in this case related to patient care) was influential in translating the individual's interest in union membership to intention to vote for a union (the US equivalent of recognition).

In their study, Oxenbridge and Brown (2002) suggested that the level at which unions engaged with management might affect the quality of "voice". Amongst service sector companies, the level of contact was with national union officials, in two out of the six accompanied by shop stewards. In production companies, the principal contact was with workplace representatives. Those with the national relationships were also found to be seeking means of "containing" union influence which, while it was valued for implementing change, was not wanted in wider areas of the company's activities. This, the authors contrasted with smaller companies which pursued a "nurturing" strategy and developed more informal relationships with local representatives. The authors concluded that: "unions had greater rights when they had informal relationships backed up with high levels of workforce unionisation".

According to Cunningham (2001), changes to employee relations polices in the voluntary sector, including pressure on pay and conditions arising from cost constraints from funders, were leading to a resistance and dissatisfaction amongst the workforce. In some cases this meant that management-led, informal information and consultation structures were insufficient, and employees were now looking for more representative structures, including unions.

In a later study, he examined the efforts of workplace union activists in two voluntary sector organisations to defend terms and conditions and win members (Cunningham, 2008). Both organisations provided services under contract to, and funded by, the public sector; they recognised unions, and they proposed negative changes to staff terms and conditions in response to economic and competitive pressure from funders. However, one ("Starlight") had little in the way of collective structures, with 20 per cent membership, only one shop steward across 175 staff, and no consultative committee meetings. The other ("Galaxy") had 27 per cent membership and 12 shop stewards across 650 staff. Organisational strength was not the only difference between the two cases –the authors saw Starlight as having less scope for action because it was tied to three or four local authorities, while Galaxy had funding from across Scotland's local authorities, central Government and the EU.

Despite these, Cunningham considers that the relative success of the union campaign at Galaxy (where a proposal to sever links with local government pay scales was abandoned) was due in part to the existence of workplace activists who were able to mobilise and send signals to convince management. In the case of Starlight (where some staff had a pay cut, and holiday entitlement was cut) a single union representative was isolated, and the union's campaign did not demonstrate that management had viable alternatives. Cunningham also concluded that in addition to local activists, at Galaxy the union had been able to use external factors – in this case the market position of the employer - to present a credible case that it was possible to make managers change their minds.

Equality
Using the data from the 1998 Workplace Employee Relations Survey (WERS, 1998), Bewley and Fernie (2003) showed that workplaces with union recognition were substantially more likely to have equal opportunity polices, and means of monitoring them, than workplaces without. Although the data did not demonstrate that there was an increased tendency for women to take up family friendly policies where unions were recognised, the availability of such policies was associated with union recognition.

The presence of unions is clearly associated with smaller pay differentials between men and women, and between black and minority ethnic workers and white workers. Using data from the Autumn 1998 Labour Force Survey and the 1998 WERS, researchers from the London School of Economics were able to show that trade unions and collective bargaining reduced the gap between male and female earnings by thee percentage points, and between black and white workers by between 1.4 and 3.3 per cent (Metcalf *et al*, 2001).

Health and safety
A briefing produced by the TUC (2004) cited a wide range of national and international sources demonstrating the beneficial role played by trade unions in promoting health and safety at work. Workplaces with unions playing a safety role showed injury reduction rates of between 24 and 50 per cent. Observation of health and safety regulations was also shown to be substantially higher in unionised workplaces.

Meanwhile, a later study of workforce participation in health and safety in non-union workplaces raised serious concerns, even though the researchers believed the employers in their chosen case studies had a better approach to health and safety than most non-union employers. For example, at the workplaces studied, managers, health and safety officers and representatives were not aware of relevant regulations; there was no evidence that workers raised concerns over health and safety, nor did they influence decisions or practical outcomes (Shearn, 2005).

Quality of care
Sheward *et al* (2005) cite a range of UK and US research dating from the 1970s up to 2002 which correlated patient outcomes (for example, mortality and complication rates) with nurse outcomes such as satisfaction, retention and sickness absence. The study, based on 8,770 nurses in England and Scotland, found that increasing the patient:nurse ratio was associated with an increased risk of emotional exhaustion and dissatisfaction amongst nurses. Although they concede that the relationship with patient outcomes may be complex, they consider that the effect on nurses has a potential impact on those they care for.

A study of nursing homes in Texas found that outcomes for residents were improved where directors of nursing were experienced and in post longer, but also where management practices included greater openness of communication, constructive feedback, participation in decision-making and helping staff to resolve conflict (Anderson *et al 2003)*. The paper suggests similar outcomes for nursing care as for the “innovation” which has been found to be encouraged by HRM1 practices (including not only establishing effective communications, but also training, occupational health and other high level interventions).

A study of 936 Stockholm doctors and nurses was conducted in 1998 – a period of some upheaval in the Swedish health care system (Arnetz, 1998). Having shown how previous

work relating the quality of patient care was linked to health workers' job satisfaction, this study focused on what factors contributed to that satisfaction. Increased workload, unsurprisingly, exerted a negative effect of satisfaction, but the quality of staff-management relations had the greatest positive effect. Arnetz summarised: "Management issues, related to how staff are kept informed and engaged in everyday decision making, are of significant importance in order to create top quality care environments".

A union could be the best vehicle for this, but this is not automatically true. As Willman *et al* (2007) point out, management may find union voice attractive particularly when faced with regulatory pressure, but only if unions concentrate on the "quality of voice" they deliver.

Clark *at al* (2001) identified that the processes of restructuring in the US health care industry were leading to problems in nurses being able to deliver acceptable levels of patient care. They concluded that if unions could credibly claim to gain a greater role in patient care decisions, they could : "argue that their presence can contribute to improved patient care" (Clark *et al* 2001).

Section 5: Summary and conclusions

- *The independent health care sector*
  The independent health care industry is a significant employer, but employment tends to be concentrated in small employers (i.e. fewer than 50 employees). In acute care in particular, the sector is experiencing a period of structural change and consolidation of ownership. It is a highly regulated industry with a growing involvement in providing services to the public sector, and the reach and extent of regulation is increasing, particularly for those contracting to the NHS or operating as charities. Pressure on costs is intensifying from both private medical insurance and the NHS.

- *Union recognition*
  Trade union recognition has been encouraged by legislation, although this recognition largely takes the form of voluntary agreements. The public sector remains the site of highest levels of union membership, but union attention is turning to the voluntary sector especially now that there more public sector contracts undertaken by the voluntary sector. It is not possible to determine the extent of recognition in the independent health care sector, but it is unlikely to be higher than within the private sector as a whole.

- The form taken by union recognition varies widely, and is expressed differently in both agreements and practice. Practice in the workplace is not only determined by the content of recognition agreements, but also by external pressures, management style and the level of union organisation in each workplace.

- *Benefits of recognition*
  Recognition can have demonstrable benefits both for employers and trade union members –but this is not automatic. For workers, the benefits can include: fairer distribution of pay, better holidays, fewer disciplinary actions, better training, safer workplaces and involvement in implementing change. For management, there can be lower turnover of staff, reductions in absence and improvements in patient care. Both can benefit from more ordered industrial relations (including equality policies) and a more effective “voice” mechanism for staff – particularly in dealing with change imposed from outside (such as regulation).

- *Union influence*
  The extent to which any of the benefits of union recognition is realised is likely to depend on the quality of the “voice” the union provides to the employees. This relies on the strength of the relationship of the union with its members, and on members’ perceptions of the capacity of their union to influence management behaviour.

- The presence of local union activists in a range of roles (such as health and safety and learning representatives) is also key to the development of union influence, and effective voice.

- *The future*
  In the near future the independent health care industry may face:
  - changes to and increases in regulation
  - intensified competition and pressure on costs
  - greater concentration of providers.

This may create consequences for the workforce not only in pressure on wages, but on working time arrangements and provision of facilities. Evidence, particularly from the USA, suggests that this may increase the desire of health workers for union representation. A trade union which already has widespread membership in the sector would be well placed to respond to this demand.

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