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The Responses of Hospital Nurses in Ireland and Southern Italy to the Rationalisation of Public Health Care, 1985-2000

Jonathan Pratschke

Thesis Submitted for the Degree of
Doctor of Philosophy

Trinity College Dublin
2003

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This thesis is dedicated to Lucia Farina,
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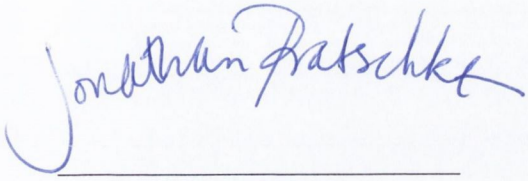

Jonathan Pratschke

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SUMMARY

This thesis seeks to address three interrelated research questions regarding changes in the funding, organisation and management of the health service in the Republic of Ireland and Southern Italy over the past two decades. The first question regards the extent to which health service rationalisation has followed a similar pattern in Ireland and Italy, the second asks what impact this process has had on nurses' working conditions and the third inquires about how the nursing unions have responded. The comparative framework for the research is based on an extension of Esping-Andersen's typology of welfare regimes.

In order to answer the research questions, a complex comparative approach was adopted comprising a clustered case study design. Four acute hospitals were selected, three in Naples and one in Dublin. Interviews were arranged with health service administrators and hospital managers as well as with union representatives at local, regional and national level and with a large number of hospital nurses. In addition, a representative survey of nurses was conducted in the case study hospitals and comprehensive literature reviews were carried out in each of the main areas of the research: policy analysis, labour process analysis, industrial relations and the sociology of health.

In the five main chapters of the thesis, I discuss health service reform, national union responses, local management strategies, nurses' work grievances and workplace union representation. I show that common pressures and a similar structural location within the European Union have given rise to comparable policy outcomes in Ireland and Italy. I then demonstrate that health service rationalisation has led to an increase in nurses' workloads and exacerbated problems of short-staffing and discuss some of the commonalities and differences that exist between Irish and Italian nurses in this regard. Finally, I show that the national union leadership in Ireland and Italy accepted health service rationalisation during the late 1980s and early 1990s as a result of participation in national agreements dealing with state restructuring, incomes policy and public sector modernisation.

One of the main findings of the research is that an analysis of the relationship between work grievances and workplace union relationship can shed light on distinctive national patterns of industrial relations. In Ireland, the weakness of workplace union structures impedes the transmission of nurses' grievances to official union structures. As a result, grievances tend to 'accumulate' at local level. This is the mechanism underlying the 'pressure cooker' model of industrial relations. As a result of recent declines in union participation in the public hospitals in Italy, nursing industrial relations in this country may also converge on a similar model.

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LIST OF ABBREVIATIONS

CGIL	*Confederazione Generale Italiana del Lavoro*
CISAL	*Confederazione Italiana Sindacati Autonomi dei Lavoratori*
CISL	*Confederazione Italiana dei Sindacati dei Lavoratori*
CONFAIL	*Confederazione Autonoma Italiana del Lavoro*
CUB	*Confederazione Unitaria di Base*
DC	*Democrazia Cristiana*
DRG	Diagnosis-Related Group
EMU	European Monetary Union
EU	European Union
FAPAS	*Federazione di Associazioni Professionali Addetti alla Sanità*
FUE	Federated Union of Employers
ICTU	Irish Congress of Trade Unions
IMPACT	Irish Municipal Public and Civil Trade Union
INO	Irish Nurses Organisation
IPASVI	*Infermieri Professionali, Assistenti Sociali e Vigilatrici d'Infanzia*
LHU	Local Health Unit
NWA	National Wage Agreement
P2000	Partnership 2000
PCI	*Partito Comunista Italiano*
PCW	Programme for Competitiveness and Work
PESP	Programme for Economic and Social Progress
PLI	*Partito Liberale Italiano*
PNA	Psychiatric Nurses Association
PNR	Programme for National Recovery
PPF	Programme for Prosperity and Fairness
PRC	*Partito della Rifondazione Comunista*
RdB	*Rappresentanze di Base*
RSU	*Rappresentanze Sindacali Unitarie*
SIPTU	Services, Industrial, Professional and Technical Union
SLAI-COBAS	*Sindacato Lavoratori Autorganizzati Intercategoriali – Comitati di Base*
SMI	Strategic Management Initiative
SSN	*Servizio Sanitario Nazionale*
UIL	*Unione Italiana del Lavoro*
VHI	Voluntary Health Insurance

I INTRODUCTION: RESEARCH QUESTIONS AND STUDY DESIGN

Introduction

This thesis seeks to address three interrelated research questions regarding changes in the funding, organisation and management of the health service in the Republic of Ireland and Southern Italy over the last two decades. The first question regards the extent to which health service rationalisation has followed a similar pattern in Ireland and Italy. The second asks what impact this process has had on nurses' working conditions and the third inquires how the nursing unions have responded to the resulting changes.

In this chapter, I will explain why it is helpful to compare Ireland with Italy and I will justify this rather innovative comparison by discussing extensions to Esping-Andersen's typology of welfare regimes. I will then describe the overall approach adopted in this thesis, which applies the tools of industrial sociology – with a particular focus on Labour Process Theory – to an occupational group that has received comparatively little attention within this area of sociology. This will lead to a discussion of research design and methodological issues, where I will explain my reasons for adopting a multi-level (local and national) and multi-method (quantitative and qualitative) approach. I will conclude this introductory chapter by providing a brief overview of the structure of the thesis, assessing the contribution made by each chapter to existing sociological debates.

Theoretical Rationale for Comparative Approach

Although there is a strong tradition of comparative policy research in Europe (see, for example, Bach et al., 1999; Casparie et al., 1990; Cochrane & Clarke, 1993; Ferrera, 1989; Freeman & Moran, 2000; O'Connell & Rottman, 1992), there are also limits to the scope of this research. As far as the Republic of Ireland is concerned, most comparative research is limited to Britain and 'core' European countries such as France and Germany (but see Clancy et al., 1992, Simkus et al., 1991 and Pochet, 1998).

Although this research helps to identify a number of the specificities inherent in the Irish experience, the absence of a clear theoretical motivation for some of these comparisons limits their usefulness. The political and economic development of the Irish Republic differs in several respects from that of Britain and other Anglo-Saxon countries, and I will argue in the following paragraphs that a different comparative approach can shed light on aspects of the Irish case that are frequently overlooked.

In common with the countries of the Southern European periphery – Italy, Greece, Spain and Portugal – Ireland experienced late and uneven industrial development and retained many characteristics of 'underdevelopment' until the 1960s and 1970s (Goldthorpe & Whelan, 1992; McLaughlin, 1993). In fact, all of these countries experienced high rates of unemployment and outmigration throughout the postwar period. As a consequence, state employment tended to play an important role within the labour market. State welfare services developed at a later stage and more rapidly than in other European countries, and the economic downturn of the 1970s and 1980s struck whilst the welfare state was still in the process of construction (Allen, 1997; Jacobsen, 1994; O'Connell & Rottman, 1992). It is therefore interesting to ask whether there are similarities between Ireland, on the one hand, and the countries of the Southern European periphery, on the other, in relation to recent changes in health policy and the policy stance adopted by the unions.

The most influential typology of 'welfare state regimes' within contemporary comparative research is that provided by Esping-Andersen (1990), who proposes a three-way classification of Conservative, Liberal and Social Democratic welfare states: "[t]o talk of 'a regime' is to denote the fact that in the relation between state and economy a complex of legal and organisational features are systematically interwoven" (Esping-Andersen, 1990: 2). Drawing on Marshall's (1950) notion of 'social citizenship', Esping-Andersen argues that three distinctive models of social citizenship may be identified within the advanced capitalist countries, corresponding to the Liberal Anglo-Saxon approach to welfare provision, the Conservative social insurance model pioneered by Germany and the Social-Democratic universalism characteristic of the Scandinavian countries.

Esping-Andersen assimilates the Southern European countries to the Conservative model, arguing that the principle of 'subsidiarity' ensures that the state only interferes where the family's capacity to service its members is exhausted[1] (1990: 27). The existence of patronage and clientelistic relationships in Southern Europe are described as a feudal attempt to address the problems generated by the commodification of labour and do not signal a departure from the basic model of the 'Conservative welfare state regime'.

A number of sociologists have argued that Esping-Andersen's typology merely generalises from the experience of the United States, Germany and Sweden, treating these countries as 'ideal types' (Bagguley, 1994: 78-9; Dent, 2000: 1). One of the problems with this approach, at least from a European perspective, is that many European countries do not fit easily into the resulting typology, including the Southern and Eastern European states as well as Ireland – practically the entire periphery of the European Union (EU). In these countries, the organisation of public health care does not coincide with any of Esping-Andersen's models and is not based on the principles of subsidiarity and corporatism. It is necessary, therefore, to reconsider Esping-Andersen's typology and to develop a more comprehensive framework in order to study changes in welfare policy throughout the EU.

Italian, Greek and Spanish sociologists have developed a number of interesting perspectives on the common features of 'Mediterranean' welfare states. For example, Trifiletti (1999) argues that the distinctiveness of the welfare state in Southern Europe lies with the fact that welfare entitlements are determined on the basis of family roles and responsibilities. Dent (2000) reinforces this observation by pointing out that implementation of the principle of subsidiarity presupposes a relatively powerful and well-organised state that is capable of imposing organisational principles across the system of public services. In Greece, Spain, Portugal and Italy, the state has historically

[1] The 1931 Papal Encyclical *Quadragesimo Anno* advocates the principle of 'subsidiarity' as a means of preventing state encroachment on voluntary arrangements: "It is an injustice and at the same time a great evil and disturbance of right order to assign to a greater and higher association what lesser and subordinate organisations can do" (quoted in Whyte, 1980: 67). Note that Catholic corporatism does not preclude state expenditure on welfare so long as subsidiary organisations provide services which are oriented towards the 'social good' and support for the family.

lacked these resources and autonomy, and the influence of clientelism and familialism tends to erode the 'universalistic' aspirations of welfare provision in these countries.

Given that other welfare state regimes are identified in abstract and not geographical terms, Dent (2000) argues that it would be inappropriate to add a 'Mediterranean' or 'Southern' cluster of countries to Esping-Andersen's typology. However, he suggests that Ferrera's (1996) focus on 'particularism' in the Italian context provides a solution to this problem: all of these states may be described as 'particularistic', as they are unable to exercise full control over welfare institutions due to their embeddedness within a social system characterised by clientelism and familialism. This weakness corresponds to the historical weakness of the central state vis-à-vis regional government. Ponzini (1998) provides a useful summary of this phenomenon:

> *In Southern Europe it is not only the welfare system which is* sui generis, *but it is also the State: this is a state which is scarcely 'Weberian', permeated and easily manipulated by organised interests (and by the political parties in particular).* (Ponzini, 1998: 15)

Dent suggests that in these countries, weaknesses inherent in the process of state formation have found expression in a multiplicity of 'particularities' rooted primarily within family networks. Kin relationships attained primacy due to the failure of the state to satisfy the fundamental welfare needs of the population. The notion of welfare state 'particularism' also provides a basis for studying welfare policy in countries located outside the Mediterranean region, as the 'transitional' welfare states found in Eastern European countries, for example, are also characterised by the salience of kinship networks. Particularistic forms of access to public services via illicit payments and private insurance are also important (Dent, 2000).

Moreover, there are considerable similarities between the structure of public welfare provision in Southern and Eastern Europe and that found in the Republic of Ireland. In the latter country, particularism manifests itself in the weakness of the Irish state vis-à-vis private interests within the welfare sector (Clancy et al., 1986) and due to the coexistence of a 'universalistic' model of welfare entitlements with a 'particularistic'

system of provision (Leahy & Wiley, 1998; O'Dwyer, 1998; O'Hara, 1998). Although clientelistic relationships play a much weaker role in gaining access to public services in Ireland than in the Mediterranean countries, direct payments provide a means of securing preferential treatment within the two-tier Irish health service (NESC, 1990). The dominant role of private organisations – primarily religious orders – in the provision of publicly-funded healthcare reflects the historical weakness of the Irish state and its unwillingness to challenge the vested interests of the Catholic Church, the Voluntary hospitals and the medical profession (Brown, 1998; McLaughlin, 1993; O'Connell & Rottman, 1992; Whyte, 1980). The notion of 'particularism' also enables us to theorise regional differences such as the sharp territorial divide in Italy, between the relatively developed 'North' and underdeveloped *Mezzogiorno*. What distinguishes the South of Italy is the *social context* of welfare provision, not the formal content of welfare policy.

Turning from health policy to union representation, the model of the 'particularistic-peripheral' welfare state also appears fruitful in this area of research. The evolution of the Irish industrial relations system diverged from that of Britain, France, Germany and other core European countries over the post-war period. For example, labour struggles were particularly intense in Ireland during the 1960s and 1970s, and, in common with the Southern European countries, this was due to the weakness and political isolation of the labour movement following the Second World War. However, shopfloor militancy during the 1960s and 1970s provided the government with an incentive to involve union leaders in debates about macroeconomic policy, welfare reform and national development, and this encouraged experiments with 'political exchange' during the mid to late 1970s.

The development of an institutionalised system of neo-corporatist bargaining in Ireland after 1987 has no parallel within the Anglo-Saxon world and appears rather anomalous within this context. Although many states looked to neo-corporatist arrangements as a response to economic recession during the 1970s, the following decade was characterised by a shift towards neo-liberal approaches and a decline in state intervention. As Ferner (1991) notes, however, attempts to rationalise the state in countries such as Ireland, Italy, Spain, Greece and Portugal were accompanied by

attempts to reform the structure of industrial relations, usually on the basis of some form of 'social dialogue' (Ferner, 1991: 18). Writers such as Crouch (2000), Hardiman (2000), Hyman (1994), Pochet (1998), Regini (1999), Rhodes (1998) and Teague (1995) have linked the development of national agreements in the European periphery with the pressures of European convergence. A distinctive model of neo-corporatism has emerged as a result, which they variously refer to as 'competitive corporatism', 'developmental corporatism' or 'organised decentralisation'.

The severity of the economic crisis in these countries and the unions' desire to avoid marginalisation encouraged union leaders to enter into talks with government and employers on measures to boost national competitiveness. Moreover, the dominant role played by populist political strategies precluded a 'radical' neo-liberal shift in policy, and the relative strength of the unions at workplace level created an added incentive for the involvement of union leaders in policy discussions. The impact of economic recession during the 1980s therefore created the conditions for the emergence of concertative bargaining in Ireland and Italy, in contrast with the Anglo-Saxon countries. Thus, the severity of the economic crisis and the political outlook of the ruling elite in Ireland and Italy ruled out the possibility of a social democratic shift in welfare policy, despite the fact that an undiluted form of neo-liberalism was avoided. As a consequence, the rationalisation of public services entailed the implementation of 'modified neo-liberal solutions' within a neo-corporatist structure of national agreements.

These observations suggest that the comparative analysis of welfare policy and union representation in peripheral areas of Europe such as Ireland and Southern Italy may be fruitful. Nevertheless, the English-language literature is relatively weak in relation to the analysis of welfare policy and industrial relations in these countries (a noteworthy exception is Bach et al., 1999). There are considerable gaps in our knowledge about the organisation and delivery of public welfare and regarding the nature of union representation in Southern Europe. Although Italian sociologists have discussed the evolution of welfare policy and union representation in Italy, these discussions are relatively inaccessible to English-speaking social scientists (Accornero, 1992; Bariletti & France, 1995; Carrieri, 1995, 1997; Corcione, 1998; France, 1997, 1999; Giorgetti,

2000; Mapelli, 1999). Moreover, there is a distinct lack of comparative analyses that focus on the peripheral countries themselves. Arguably, this is essential in order to prepare the ground for broader theoretical frameworks that facilitate analysis of welfare state restructuring in Europe.

One of the primary aims of this thesis is therefore to provide a detailed comparative analysis of changes in the funding, organisation and management of public health care in Ireland and Italy since the 1980s. I will show that there are considerable similarities between the experiences of these two countries and that their inclusion within a single 'particularistic-peripheral' welfare state regime is therefore warranted. In relation to the specific question of health service restructuring, I will show that the responses of the main unions are comparable in both countries. By analysing nurses' work grievances, I will also show that there are similarities between the ways in which Irish and Italian nurses evaluate their work situation. These similarities are all the more striking given the considerable differences that exist in relation to the gender composition, age profile and labour market situation of these two groups of nurses.

Nevertheless, there are also a number of differences between Ireland and Italy in relation to the functioning of the health service and management strategies at hospital level. The social and political context of workplace unionism in Ireland and Italy leads to radically different forms of union organisation at hospital level and gives rise to distinct *local* responses to rationalisation. The 'pay-off' of the comparative approach in relation to health service rationalisation therefore rests with its ability to identify the preconditions for different kinds of strategic response by managers and union representatives and to highlight distinct forms of local unionism.

Research Approach

In this thesis I will treat nursing primarily as a form of *work* and I will approach the hospital above all as a *workplace*. In contrast, nursing researchers and sociologists of health tend to study nursing from the perspective of the professional capacities, status and training of nurses and to study the hospital primarily in terms of its role in service provision (Abbott & Wallace, 1990; Barrington, 1987, 1998; Davies, 1995; Leahy, 1998; Mackay, 1989, 1993; McAuliffe & Joyce, 1998; Porter, 1995; Robins, 1997; Robinson & Le Grand, 1993; Salvage, 1985; Stacey, 1986; Vicarelli, 1996; Witz, 1992). Nurses' role in providing care obviously has important consequences for their self-understandings, for the nursing labour process and for nursing trade unionism. However, nursing is above all a form of work and the tools developed by industrial sociologists have considerable explanatory power in relation to this area of employment, as I will show in later chapters.

Labour Process Theory was initially developed by a group of (mainly) British social scientists and takes Marx's account of the 'capitalist labour process' as its point of departure. The aim of these researchers – who come together each year for the Labour Process Conference – is to develop middle-range theoretical hypotheses that can guide empirical research on management strategies, the transformation of work and forms of union organisation at workplace level (Carter, 1995, 1996; Smith & Thompson, 1997; Sturdy et al., 1992). However, as Smith et al. (1991) indicate, the public services sector has been relatively neglected by Labour Process theorists:

> *In general this sector has been neglected by labour process analysts, not least because of the difficulties in translating to the public arena a theory concerned with the extraction of surplus value for the purposes of private accumulation. By contrast, in the public sector the production of goods and services is often subsidised and non-profit criteria frequently condition the purpose and organisation of work.* (Smith et al., 1991: 2)

One of the key insights of this theoretical approach is that the nature and consequences of organisational change and management strategies can be studied most effectively at local level – within the workplace – and that the analysis of work grievances, union organisation and responses to change must be based on a qualitative understanding of social relationships within the workplace. Thus, as well as studying health policies and union responses at national level, the following chapters will provide a direct, first-person account of health service organisation, management strategies, work grievances and union representation.

Research Design

In order to address the research questions presented at the beginning of this chapter, a rather complex comparative approach was required. As a consequence, four acute hospitals were selected, three of which are located in Naples and one in Dublin (see Appendix A for an outline of the selection of the case study hospitals). These hospitals were chosen primarily on the basis of their size and importance within their respective regional health services. Rather than pursuing a 'representative' sample of hospitals, I adopted a purposive selection procedure that focused on the 'pinnacle' of the health service in both regions. Given the strategic importance of the large, acute hospitals to the public service unions as well as health service administrators, these hospitals constitute a crucial testing-ground for the reforms.

As far as the first research question is concerned (regarding the similarities between Ireland and Italy in relation to health service rationalisation), interviews with health service administrators and hospital managers were carried out, in addition to a detailed review of literature on health policy and organisational change. In order to answer the second research question (the impact of rationalisation on nurses' experience of hospital work), I interviewed a large number of hospital nurses, conducted a representative survey of nurses in the case study hospitals and augmented these forms of data collection by observing nurses at work within their wards. Finally, in order to answer the third research question (the nature of union responses to rationalisation), interviews with local, regional and national union representatives were arranged and a large quantity of union posters, newsletters and publications were analysed.

The integration of interviews, survey data and non-participant observation yielded a number of substantial benefits, particularly as 'triangulation' provided the possibility of constantly checking and evaluating research findings. The circulation of a questionnaire in the hospital wards facilitated the recruitment of interview volunteers and gave rise to a quasi-random sample of interviewees with much broader coverage of the nursing workforce than would otherwise have been possible. The distribution of questionnaires also provided a pretext for extended periods of observation within the wards, and this provided a number of insights into nurses' work relationships, their relationship with patients and their attitude towards union organisation.

A large quantity of quantitative and qualitative data was utilised during the preparation of this thesis. The survey of nurses received 855 responses and interviews were conducted with 55 hospital nurses, 6 managers and administrators, 11 full-time union officials, 13 local union representatives and one professional representative. The process of data collection therefore involved a multi-method approach comprising a survey, individual interviews, focus groups and non-participant observation. It would have been difficult to carry out a comparative study of hospital nursing in Dublin and Naples without having access to basic survey-based information on the socio-demographic characteristics, union involvement and attitudes of the nursing workforce in these hospitals. There are considerable differences in relation to the gender composition, age profile and educational background of nurses in Ireland and Southern Italy, and these differences necessitate a sensitive study of the relative influence of individual attributes and structural aspects of nursing work on union organisation amongst nurses.

Because of the complexity of the data collection process and the wide range of methodological techniques utilised, I have decided to incorporate all discussion of methodological issues within the text of the thesis, avoiding a distinct 'Methodology' chapter. I hope in this way to link methodological and substantive discussions and to provide information on analytical techniques where this is most relevant. In addition, technical aspects of the administration of the survey and the organisation and coding of interview transcripts are dealt with in Appendix A and B respectively.

Overview of Chapter Structure

In the following paragraphs I will provide an overview of the structure of the thesis and indicate how each chapter contributes to the existing literature on health service rationalisation and union representation amongst hospital nurses. In Chapter Two, 'The Rationalisation of Public Health Care in Europe, 1985-2000', I provide a detailed discussion of recent changes in health policy and health service management in Ireland and Italy. I begin by describing the historical evolution of state healthcare provision in these two countries, before surveying the social, political and economic context of health service rationalisation during the 1980s. I then define the concept of 'rationalisation' and provide a comparative analysis of the main elements of this process: managerialism, organisational change and marketisation. I pay considerable attention to international policy diffusion in Chapter Two, focusing on the role of 'casemix funding mechanisms' in the Irish and Italian health services. I make a number of observations in relation to 'convergence' and 'national diversity' in European welfare policy, emphasising the role of economic competition in encouraging convergence within the European periphery.

In Chapter Three, 'Union Responses to Health Service Rationalisation', I explore how the involvement of the dominant union actors in concertative bargaining arrangements emerged in Ireland and Italy towards the end of the 1980s and during the early 1990s and I look at how this influenced their response to health service rationalisation. I look at the distinctive positions adopted by different unions, relating these to their institutional structure, political affinities, cultural inheritance and ideological outlook. To this end, I also provide a short overview of the evolution of the Irish and Italian union movements since the Second World War

In the course of Chapter Three I show that reductions in health spending and changes in the management of the health service during the 1980s and 1990s coincided with the consolidation of neo-corporatist bargaining and were implemented on the basis of a 'social dialogue' between employers, government and unions. The backdrop to the restructuring and rationalisation of the health service during this period is of crucial importance, as it involved a severe economic and fiscal crisis in both Ireland (1987) and Italy (1992). Although the union leadership consented to health service rationalisation,

this decision gave rise to tensions both within and between the various union actors. During the second half of Chapter Three I explore these tensions in considerable detail, focusing on the differences that exist between the various unions and the relationship within each organisation between the national leadership, local representatives and union members. I discuss neo-corporatism and other theoretical frameworks for studying union representation and the state and evaluate their explanatory power in relation to concertative bargaining in Ireland and Italy. I conclude Chapter Three by describing the nurses' pay campaign in Ireland (1996-1999) and linking this with the effects of health service rationalisation on nurses' pay and working conditions.

In Chapter Four, 'Management Strategies and Constraints in the Irish and Italian Health Services', I examine how local managers and health service administrators have interpreted, implemented and at times resisted the programme of health service rationalisation described in Chapter Two. Given the relative lack of empirical research on managerial responses to rationalisation in Ireland and Italy, this chapter makes a substantial contribution to the empirical social science literature on health service reform. Quite simply, we know very little about what has happened at hospital level following the legislative changes introduced in the early 1990s in these two countries. The chapter begins by sketching out the social context of public service management in Ireland and Southern Italy. I then discuss the nature of 'managerialism' within the health service reforms and link this with alternative forms of managerial 'rationality' and with debates about New Public Management (NPM) in Anglo-Saxon countries.

The core section of Chapter Four is concerned with the analysis of management strategies within their local institutional context. I follow Baeza, Salt & Tilley (1993) in distinguishing between the subjective features of managers' environments, their primary strategic goals and the external and internal factors that either facilitate or prevent the realisation of these goals. I conclude Chapter Four by weighing up the evidence in relation to the emergence of a 'strategic' management function within the health service in Ireland and Southern Italy. As administrative traditions in Dublin and Naples stand in marked contrast to the new managerial models, it is important to assess the extent and nature of the recent changes.

In Chapter Five, 'The Work Grievances of Hospital Nurses in Ireland and Southern Italy', I provide a differentiated analysis of the outlook, opinions and orientations of hospital nurses. The central focus of this chapter is the concept of 'work grievances', defined as issues that nurses identify as problematic or detrimental to their well-being. I show how grievances emerge from nurses' collective experiences in the workplace and how they come to be identified and recognised by nurses themselves. I then link grievances with relatively enduring contradictions inherent in the work situation and provide an explanation for eight 'families' of nursing grievance. The central aim of the chapter is to explore the complex processes that mediate between the hospital labour process, nurses' experience of work, their identification of work grievances and the subsequent definition of the 'bargaining agenda'. These processes are of considerable theoretical interest, as they mediate between the structural characteristics of the Labour Process, on the one hand, and union participation, renewal and resistance, on the other (Smith & Thompson, 1990). Given the potential benefits of linking these areas of analysis, it is rather surprising that the concept of 'work grievances' has not received greater attention from Marxist scholars. Arguably, middle-range theories that account for the origins of various work grievances can bridge the gap between the study of social structures and the interpretation of individual agency in the context of labour process theory (Burawoy, 1979, 1985; Knights & Willmott, 1990).

In Chapter Six, 'The Representative Relationship: Nurses and Their Unions', I trace the links between nurses' work grievances and their union involvement at workplace level. The existing literature on workplace unionism suggests that the decentralisation of decision-making can encourage the 'renewal' of workplace union organisation (Fairbrother, 1994a, 1994b, 1996; Fosh, 1993; Fosh & Cohen, 1990; Dundon, 1998; Foster & Scott, 1998). This, together with the important role accorded to strategic management in the health reforms, constitutes the fundamental justification for studying union representation at *workplace* level. The chapter begins with a discussion of the 'representative relationship', the social relationship between nurses and their workplace union representatives. I use this concept to emphasise the relational aspects of union representation and its sensitivity to the social context. I then provide a brief discussion of theoretical approaches to the study of union representation, with a particular focus, once again, on Labour Process Theory. This permits the identification of a range of

tendencies that are inherent in union representation, including tendencies towards 'routinisation', 'bureaucratisation', 'participation', 'democracy' and 'resistance', as well as the conditions under which these are most likely to occur.

In the second half of Chapter Six I demonstrate the explanatory power of these concepts by drawing on the empirical data gathered during the fieldwork phase. I provide an assessment of the strengths and weaknesses of workplace union organisation in the case study hospitals and analyse current trends in relation to participation, membership levels and union renewal. One of the main themes of the chapter is the sensitivity of union representation to the social context. This leads to a discussion of union clientelism and corruption in Italy and the deferential occupational culture of nursing in Ireland. I then discuss nurses' evaluations of their representatives as well as their aspirations in relation to local union representation. Thus, Chapters Five and Six provide a theoretical framework for the study of workplace unionism and demonstrate that the empirical analysis of nurses' work grievances can shed light on union membership, participation and renewal. These two chapters draw heavily on the survey data, interviews and direct observation and illustrate the ways in which multi-method approaches to social research facilitate 'triangulation' (Denzin, 1978).

Finally, in Chapter Seven, I draw together the different strands of the research and present my conclusions. Building on the analysis of health policy, management strategies, nurses' work grievances and union representation presented in the five main chapters of this thesis, I conclude by providing some general comments regarding the challenges currently facing the nursing unions. Chapter Seven is divided into three sections, corresponding to the three main research questions that guide the research. In each of these sections, I summarise the main findings and show how these relate to the existing social science research literature.

II THE RATIONALISATION OF PUBLIC HEALTH CARE IN EUROPE

Introduction

In this Chapter, I will provide an overview of the changes that have taken place since 1985 in the funding, organisation and management of the public health service in Ireland and Italy. I will begin by providing a brief summary of the historical development of public health care in these two countries, before describing the social, political and economic context of the recent reforms. The restructuring of the health service during the 1990s took place against the backdrop of a severe economic crisis in both countries. It involved a far-reaching programme of 'rationalisation', embracing an initial period of reductions in staffing levels and real health spending as well as a subsequent phase of organisational innovation. I will describe this process and explore the implications of rationalisation in relation to recent discussions of the New Public Management in the Anglo-Saxon literature.

The Historical Development of Public Welfare Provision in Ireland

Following Independence, the evolution of Irish welfare policy diverged from the British model and a trend towards welfare 'residualism' asserted itself. This was primarily due to middle-class concerns about taxation rates, although the *laissez-faire* ideology that dominated the public administration also played a role in discouraging state intervention (Allen 1997). The Catholic Church was also opposed to public welfare provision and sought to maintain religious control over education and health care on the basis of a public charity model. As a consequence, the welfare services provided by the state at the end of the Second World War differed only marginally in their essentially residual nature from those in existence at the end of the nineteenth century (Maguire, 1986; McLaughlin, 1993)[2].

[2] Due to the onset of the First World War, followed by the War of Independence and Irish Civil War, the 1911 British National Insurance Act was never implemented in Ireland.

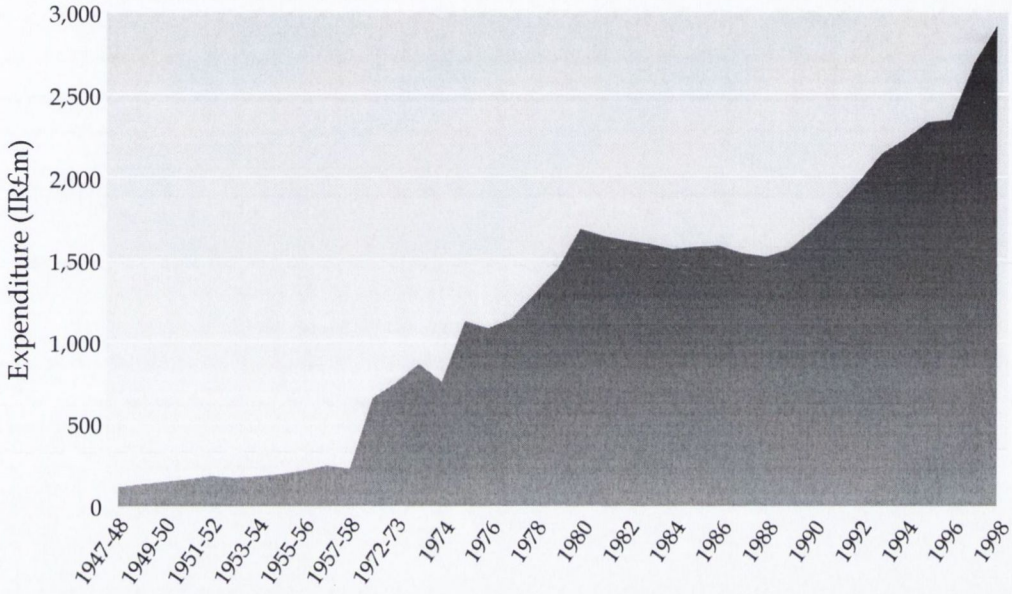
The primary motivation for the development of a public health service in Ireland after World War Two was the growing awareness that the health status of the Irish population was lagging behind that of other European countries. This was most apparent from morbidity and mortality rates associated with infectious diseases such as Tuberculosis, which were on an *upward* trend in Ireland, in contrast to the rest of Western Europe. In fact, the Health Act 1947 introduced a free, comprehensive Tuberculosis service throughout Ireland and the Health Act of 1953 extended hospital care to approximately 85 per cent of the population (Commission on Health Funding, 1989: 35). Maternal and infant mortality were very high during the first two decades of the twentieth century and infant mortality rates increased during the 1930s. Free maternity and infant services were thus extended after the Second World War. However, the Church and medical profession joined forces to block the 'Mother and Child Scheme' in 1951 and this prevented the development of a system of universal entitlements (cf. Browne, 1986; O'Connell & Rottman, 1992). Thus, despite an awareness of unmet health needs in the Irish population and initial attempts to establish universalistic welfare services, the weakness of the state vis-à-vis particular interests had a strong influence on the resulting reforms.

Due to the post-war expansion in entitlements, the existing hospitals were unable to meet the demand for health care. The 'Voluntary Hospitals' had become dependent upon fee-paying patients by the 1940s (Brown, 1998: 173). This situation was acknowledged by the Hospitals Commission in 1933, which noted the existence of a *de facto* two-tier system of access to the Voluntary hospitals. The power and influence of the Voluntary Hospitals – and more importantly, the power of the Catholic Church that owned and ran the majority of them – ensured that the subsequent reorganisation of the public hospital network did not interfere with their autonomy (Brown, 1998: 176).

Thus, public health care emerged much later in Ireland than in the European 'core' countries and the effective provision of public services did not take place for many years after formal policies were put in place. This was due to the opposition of powerful social actors to the consolidation of a 'welfare state' in Ireland. However, after the late 1950s, when a new development strategy was adopted, the Irish state began to invest more heavily in welfare provision. Whereas social spending had fallen during the 1950s

(from 16% of GNP in 1951 to 14% in 1959), there was a rapid increase during the following decade. From 11.7 per cent of GDP in 1960, state spending reached 23 per cent in 1981, only slightly below the OECD average of 25.6 per cent (Maguire, 1986: 286-7, 345). Figure 2.1 below shows the principal dynamics of state spending on health care in Ireland over the course of the post-war period.

Figure 2.1 Non-Capital Expenditure on Statutory Health Care in Ireland



Source: Department of Health (1947-98), *Health Statistics*. Values are held constant at 1996 prices.

Arguably, the shift towards an 'open economy' after 1958 placed pressure on the Irish state to keep pace with international developments in public welfare provision. In order to entice multinational corporations, it was evident that the state would have to take steps to boost the productivity of the workforce. The growth in the economy after the '1958 turn' was therefore accompanied by an expansion in social spending, leading to free secondary education in 1967 and grants for third level education in 1968. Although growth in manufacturing employment during the late industrial expansion was relatively modest, peaking during the 1970s (O'Connell & Rottman, 1992: 213), a rudimentary welfare state nevertheless took shape; laws were passed providing coverage against occupational injuries, allowing for redundancy payments, creating a 'choice-of-doctor' scheme and providing a range of pay-related-benefits.

During the 1970s, public sector spending grew at a higher rate in both Ireland and Italy than in the more affluent 'core' European states, and public employment also increased rapidly. These increases were not granted by social democratic governments, and explanation for welfare expansion must arguably be sought in their competitive integration into the international economy and the demands that this placed upon the state:

> *The welfare state expanded in Ireland in spite of the weakness of left-wing political parties, and neither the timing of that expansion nor the nature of the new citizenship rights can be explained by reference to working class strength.* (O'Connell & Rottman, 1992: 239)

Although adherence to Catholic corporatist principles meant that the role of the state in the *delivery* of social services was not as extensive as in other countries, the programme of investment that occurred during this period marked a decisive change in attitudes towards public welfare. However, corporatist ideas continued to shape the delivery of services in Ireland during the 1960s and 1970s, and the growth in public expenditure did not undermine the role of private and voluntary institutions in the delivery of health care (McLaughlin, 1993).

This highlights an important aspect of the development of public health care in Ireland, namely the veto imposed by the Catholic Church on the establishment of a national health service. This point emerges from policy documents such as the *Report of the Commission on Health Funding* (1989), which praises the 'complementary role' of the private health care sector in Ireland. Barrington (1987) goes even further, referring to the 'extraordinary symbiosis' between the public and private sectors in health care provision. The NESC report *A Strategy for the Nineties* (1990) begins with a detailed theoretical discussion in which the superiority of a universal, comprehensive national health service is asserted. But the conclusions stand in marked contrast to the preceding discussion: "...in adopting the arguments in favour of a publicly financed system, the Council recognises that a role will remain for private finance in the total health care system." No justification for the existence of private health care is provided.

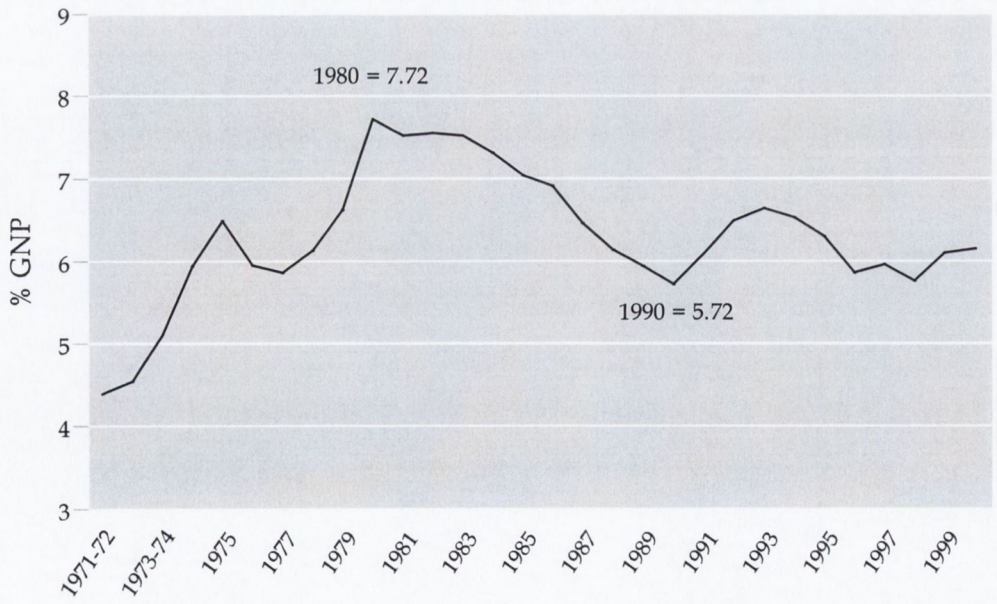
The reason for this only becomes clear in a later section, entitled 'Should private hospital care exist?'

> *The answer to this question, in the Commission's analysis, is pre-determined by the social and political context in which the healthcare system operates.* (NESC, 1990: 287)

Health Policy in Ireland, 1970-2000

The 1966 White Paper on health care provision in Ireland recognised that a further reform of the health service would necessitate greater funding and involve a shift from local government to the regional management of health care. With this aim in mind, the 1970 Health Act established eight Health Boards which were financed from general taxation rather than local rates. These Boards were assigned the task of managing the new 'regionalised' health service. This basic structure remained largely unchanged until 1995, and the 1970s saw a major expansion in health spending (Figure 2.3 below provides an overview of health spending in Ireland as a percentage of GNP).

Figure 2.3 Public Health Spending in Ireland as a Percentage of GNP



Source: Department of Health (various years), *Health Statistics*. Dublin: Stationery Office.

Following the rapid expansion in health spending during the 1970s, strong pressure was brought to bear upon the Irish health service over the course of the following decade. This led to a decline in real spending on health, although substantial increases followed during the 1990s (see Figure 2.1)[3]. Along with the Italian cuts in 1992-93, this was one of the few instances in which a European government has reduced real health spending over the last twenty years. The primary motivation for the reduction in public spending was the crisis in the public finances. In 1986, the national debt was three times larger than it had been in 1980 and high rates of unemployment led to increases in spending on social services. Because of the difficulties in servicing this debt and funding social welfare, the public sector payroll became the central focus of Government action (Gunnigle et al., 1999: 204). Brown & Chadwick (1997) describe the decline in health expenditure in Ireland during the 1980s as 'exceptional' within the OECD context. In its 1997 Economic Survey of Ireland, the OECD comments that:

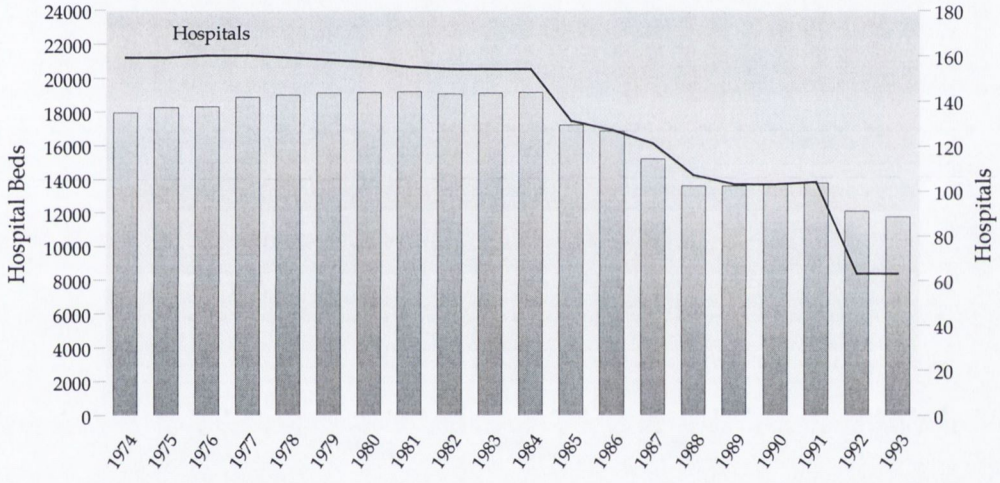
> *Ireland is among the few OECD countries that has experienced a reduction in the share of GNP devoted to health – taking public and private expenditure together – in the period 1980 to 1993. The drop in the share has been about 23 per cent and this contrasts with a 24 per cent increase seen in thirteen other OECD countries for which data is available.* (OECD, 1997: 128)

The reduction in spending was concentrated in the hospital sector, where a decline of nearly 15% occurred between 1980 and 1988 (Brown & Chadwick, 1997: 195). There was a 20 per cent decline in acute hospital beds, a 19 per cent reduction in average patient stays, a 25 per cent decline in hospital bed-days and a 5 per cent decline in discharges from the acute hospital system (Wiley & Fetter, 1990: xii).

[3] Due to the rapid expansion in the Irish economy during the latter period, however, health spending actually declined as a percentage of GNP after about 1992.

The number of nurses in the public system decreased from 25,261 in 1984 to 23,127 in 1988 (NESC, 1990)[4]. The cuts in hospital beds were achieved by closing wards and smaller hospitals, and this occurred mainly during the late 1980s. As a result, the number of acute hospital beds in Ireland declined from 14,868 in 1985 to 11,937 in 1996. Charges were also introduced for outpatient services and inpatient care in 1987, although medical card holders were exempt from these (OECD, 1997). Figures 2.4 and 2.5 below provide a graphic illustration of the reduction in the number of hospitals and hospital beds during the 1980s and the drop in the number of patients treated.

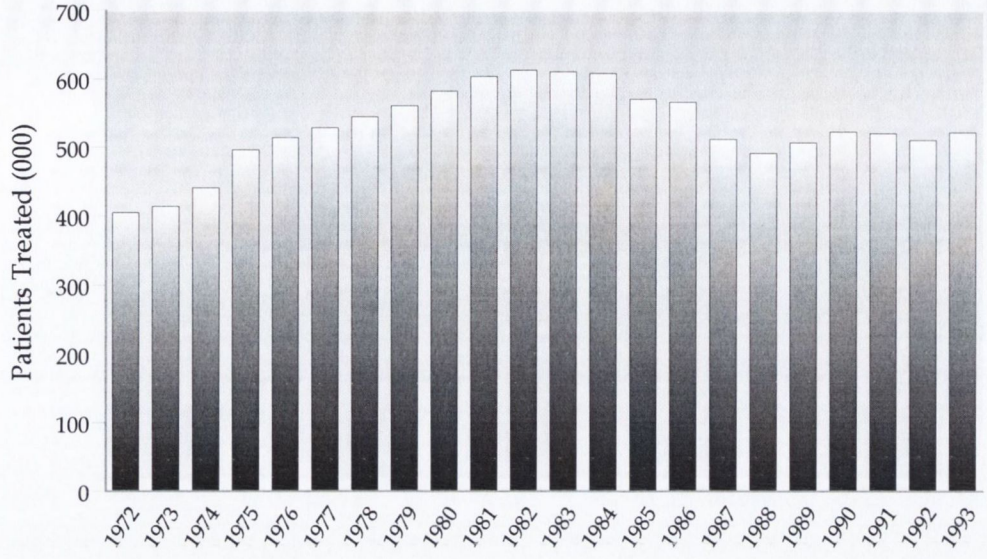
Figure 2.4 Publicly-owned Hospitals and Beds in Ireland



Source: Department of Health (various years), *Health Statistics*. Dublin: Stationery Office.

[4] Honohan (1999) points out that "[a] squeeze on recruitment had already begun in 1981, with the result that Exchequer-financed employment had fallen by 2 per cent in 1982-85, compared with an increase of 15 per cent in the previous four years. The tighter policy from 1987 brought numbers back close to their 1978 level by 1991, yielding a gross saving in pay costs of the order of 2 per cent of GNP. Since 1991, the decline in numbers has only partly been reversed" (p. 95, footnote 7).

Figure 2.5 Patients Treated by the Public Health Service in Ireland



Source: Department of Health (various years), *Health Statistics*. Dublin: Stationery Office.

In addition to the cuts in beds, personnel and health spending during the late 1980s, this period also culminated in the publication of an important policy document, *The Report of the Commission on Health Funding* (1989). The Commission was established by Fianna Fáil in 1987 with the following terms of reference:

> *To examine the financing of the health services and to make recommendations on the extent and source of the future funding required to provide an equitable public health service and on any changes in administration which seem desirable for that purpose.* (Commission on Health Funding, 1989: v)

Its establishment corresponded with the growing realisation that the reduction in spending levels achieved in the late 1980s had not altered overall efficiency levels. The Commission Report takes as its point of departure the relatively brief comments contained in the NESC report *A Strategy for Development 1986-1990* on the health service. In addition to closing inefficient structures, NESC argues, the functioning of the health service as a whole must be scrutinised. Tracing the evolution of health policy over the course of the 1990s, it is now clear that the *Report of the Commission on*

Health Funding had a great influence. In essence, this report set the terms for the debate about health care in Ireland for more than a decade.

The 1990 Dublin Hospital Initiative Group made a number of recommendations in relation to the management of hospital workloads and recommended restructuring the Eastern Health Board as well as instituting a system of service contracts with voluntary agencies to facilitate the coordination of services. These recommendations were adopted in 1991 in the *Minister's Statement on the Restructuring of the Eastern Region*, which emphasised the devolution of responsibility to the lowest level possible, the improvement of coordination between hospital and community-based services, the need for a clearer definition of roles and a constant search for efficiency (O'Hara, 1998: 30). All of these issues had been explored by the Commission in its 1989 report.

In relation to the management of the health service, the Commission recommended "clearly defining the roles of the Minister and Department, the health boards and their Chief Executive Officers" (p. 15), "transferring responsibility for the overall management of health services to an executive authority" (p. 15), "clearly defining the role to be played within the healthcare system by voluntary agencies and, in particular, the nature of their relationship with local management in terms of coordinating objectives of service provision" (p. 16) and "enhancing the evaluation function within the planning and monitoring of services" (p. 16):

> *The role of each public hospital at local, regional and national level, and its catchment area, should be defined explicitly. Each hospital should then be funded for the provision of an agreed level of service to public patients, based on the activity level implied by its role and catchment area, and the case-mix based cost of meeting this.* (Commission on Health Funding, 1989: 19)

It was above all the 1994 document *A Strategy for Health* which translated the recommendations of the Commission on Health Funding into concrete policy measures. Building on *Health – The Wider Dimensions* (1986), the 'Health Strategy' emphasised quality, equity and accountability as the core principles guiding the Irish health service. It indicated that in the future the role of the Department of Health and Children would

be to chart the strategic direction of the service, rather than involving itself in the day-to-running of the health services. This was one of the core recommendations of the Commission, and is consistent with the ethos of the *Strategic Management Initiative* (SMI). The Health Strategy and SMI mark a high point in the implementation of the 'New Public Management' in Ireland.

The Health Strategy also criticised the lack of clarity with regard to the roles and responsibilities of the Health Boards and their Chief Executive Officers (another issue raised initially by the Commission on Health Funding), their lack of accountability and the over-involvement of the Department of Health in the detailed management of the health service. The Health (Amendment) Act 1996 tackled these issues by strengthening the financial accountability of the Boards and clarifying the roles of their members and of Chief Executive Officers. This Act states that Health Boards have an obligation to secure the most beneficial, effective and efficient use of available resources, to co-operate with voluntary bodies in providing services to those residing within their catchment areas, to co-operate with Health Boards, Local Authorities and other statutory bodies and to implement government policy (Section 2). Each Health Board must submit a service plan to the Minister on an annual basis (Section 6), and plans should "include a statement of the services to be provided by the health board and estimates of the income and expenditure of the board for the period to which the plan relates" (section 6.2). The Chief Executive Officer of the Health Board has the legal authority and political obligation to intervene directly to curtail service provision in cases of repeated 'overspending'. The OECD welcomed these changes in the management of the Irish health service in 1997:

> *The government has also introduced a series of measures to strengthen the management capacity of health services. This plan aims to improve the human resources of the hospitals by introducing comprehensive performance appraisals for staff, encouraging continuing training and improving the selection, promotion and recruitment procedures. In addition, the senior executive of health authorities and boards will be placed on fixed-term contracts.* (OECD, 1997: 145)

The 1994 'Health Strategy' identified 'a particular problem' in the Eastern Health Board area, characterised by the absence of an authority with overall responsibility for co-ordinating services. The 1997 *Interim Report of the Task Force of the Eastern Regional Health Authority* advocated a new Health Authority for the Eastern region, which would have the role of drawing up multi-annual strategic plans which identify the health needs of the population in the context of national policy guidelines. The Health Authority should also submit a budget for the provision of services within the spending limits determined by its allocation (O'Hara, 1998: 21; O'Shea, 1998). Three Area Health Councils were created with the role of identifying health needs and priorities in their own areas, ensuring that service agreements with hospitals are adhered to, co-operating with voluntary providers and monitoring the overall provision of health and social services. During the consultation process, concerns were expressed about the need for a clear separation of the purchaser and provider roles:

> *It is now envisaged that the Authority at central level should have no management role in direct delivery of services. Services currently provided by the Eastern Health Board should be provided by the three Area Councils, with significant responsibility being legally vested in them for that purpose. This would then create a simple structure in which the Central Authority would have, in effect, similar arrangements with all its providers – the 35 voluntary agencies and the three area councils.* (O'Shea, 1998: 63)

Recent changes in the Comptroller and Auditor-General Acts mean that the accounts of the Health Boards are subject to much closer monitoring, with the aim of ensuring accountability for all funding voted by the Government (Barrington, 1998: 95). Thus, it is apparent that the process of health service rationalisation has picked up pace during the 1990s, and the resulting raft of legislative reforms, organisational changes and policy statements signal a considerable shift in the outlook of the Department of Health. The nature of this shift recalls the main themes of the New Public Management in Britain: decentralisation of financial responsibility and decision-making authority, strengthening of strategic management, an emphasis on agreed service levels, service evaluation, a customer focus and a distinction between policy-makers, purchasers and providers of health care.

The Historical Development of Public Welfare in Italy

The nineteenth-century Italian health service, like the Irish, was based on a network of charitable institutions and workers' organisations, alongside a limited form of public provision. However, the subsequent development of state health care was more rapid than in Ireland. Arguably, this was due to the greater industrialisation of the North of Italy; clearly, the competitiveness of the large Northern manufacturing companies was partly dependent upon the health status and productivity of their workforce. A social insurance scheme against accidents at work that applied exclusively to workers in these factories was established in 1898 (CGIL, 1997). Social insurance (including insurance against injury, sickness, old age and unemployment) became obligatory in 1919, after which time the state provided funding for social assistance.

In contrast to the Irish experience, the Fascist state intervened heavily in the provision of health care during the inter-war period. The 28th *Carta del Lavoro* in 1927 introduced the *casse mutue*, or public insurance companies, which collected health contributions from workers and employers. After the Second World War, this system was extended to the self-employed. Its coverage subsequently increased from just 45 per cent of the labour force in 1945 to more than 90 per cent in 1975 (cf. Cazzola, 1997). Ferrera (1989) argues that by the end of the 1950s the *casse mutue* had become a major pillar of the Italian welfare state.

As in Ireland, economic conditions and the influence of the Catholic Church delayed the creation of a comprehensive public welfare system in Italy after the war[5]. Although many western European societies espoused a commitment to extending public welfare provision during the 1940s and 1950s, Ireland and Italy represent exceptions to this pattern (O'Connell & Rottman, 1992: 231). Instead, the health service developed in an unplanned fashion on the basis of a combination of public funding and mainly private provision. As a result of the lack of coordination and control, conditions in the Italian

[5] The 1929 Concordat had brought Church and State closer together, and the Church had a considerable influence over the development of the system of the mutue, which left both religious insitutes and medical staff with considerable autonomy.

hospitals deteriorated rapidly in the 1960s. This was due to the increased demand for care, the costs involved in providing hospital treatment, as well as the clientelism, corruption and waste that characterised the Italian hospital system. By the 1970s, the *casse mutue* were on the verge of bankruptcy:

> *The inequalities in coverage and benefits, the institutional fragmentation, duplication in therapeutic pathways, the wastage of human and financial resources were nothing less than the outcome of a legislative approach which had, for years, considered health care as an instrument of social consensus, a reservoir of jobs and a source of covert funding.* (Vicarelli, 1996: 3)

This formed the backdrop to the establishment in 1978 of the Italian *Servizio Sanitario Nazionale* (SSN), or National Health Service. Pressure for reform was also building up as a result of the transfer of powers to the *Regioni a statuto ordinario*[6] and due to the rise in the electoral strength of the Italian Communist Party (PCI). The decision of the Communist Party to support the Christian Democrat coalition government in the late 1970s also facilitated this development (Abse, 1985; Hellman, 1988).

The political conjuncture is not the only, or even the most important, factor in accounting for the establishment of the Italian National Health Service. In fact, it is apparent that the creation of the SSN was viewed by the Italian ruling elite as a form of 'modernisation' that would enhance economic growth. In fact, policy documents from the late 1970s indicate that a comprehensive, universal welfare system along the lines of the British NHS was viewed as the most efficient, equitable and cost-effective model. On the other hand, the health service was seen as an instrument for generating social consensus and gathering votes (Berlinguer, 1994; Ferrera, 1989; Vicarelli, 1996). Ironically, the integration, decentralisation and public character of the Italian National Health Service, with its emphasis on party-political control, created the conditions for a clientelistic strategy (Vicarelli, 1996: 4-5). The immediate manipulation of no less than 11,000 appointments to the Local Health Units – in which all of the political parties participated – created an administrative stratum lacking in technical skills and

[6] See law number 382/1975 and subsequent decrees covering the sub-regional organisation of health care.

managerial competence and completely dependent upon the political sphere for its authority (Berlinguer, 1994).

According to Vicarelli (1996), an ideological and political onslaught also began against the SSN as soon as legislation was passed in 1978 (decree number 833). Recruitment was curtailed, spending on social services was frozen and very few new hospitals were built. Many of the regulations necessary for the correct functioning of the health service were delayed, including the drafting of the National Health Plan. By law, this should have been passed in 1979, but actually appeared for the first time in 1993. As a consequence, the co-ordination and development of health services was extremely difficult and funding was determined by the general politics of budget restraint and not on the basis of an analysis of health needs. The financial constraints faced by the public hospitals during the 1980s – in conjunction with the poor quality of care provided – facilitated the expansion of private health care, and this provided profitable opportunities for the medical profession:

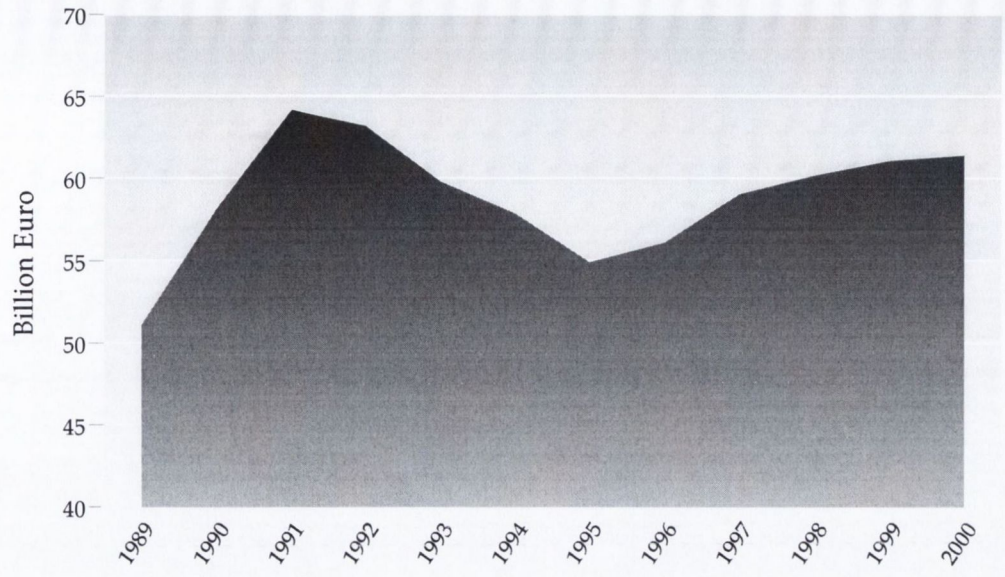
> *The medical profession, moreover, has helped to accentuate the inefficiency of the health service, reducing citizens' trust in public services and pushing them into searching for privileged channels which can reduce waiting times and provide access to certain procedures, and even leading them to approach private clinics where the very same doctors enjoy lucrative employment opportunities.* (Vicarelli, 1996: 9)

The establishment of the Italian SSN raises interesting questions about the role of both the Catholic Church and the medical profession in Italian society. As I have already indicated, the most significant obstacle to the establishment of a National Health Service in Ireland was the vested interest of the Church and medical profession in the existence of autonomous voluntary organisations and a market for private health care. But it is important to recognise that the Voluntary Hospitals represent a continuity with the charitable tradition of the religious orders. In contrast, the majority of the Italian hospitals were run by semi-public insurance schemes that dated back to the Fascist period, and the financial collapse of the *mutue* during the 1970s necessitated a comprehensive reorganisation of the system.

In fact, the remaining religious-run hospitals benefited from the establishment of the SSN, as private clinics could obtain public funding and operate under the auspices of the National Health Service (Borgonovi & Meneguzzo, 1990: 224; Zanetti & Montaguti, 1990: 247). A mixed system of healthcare emerged in Italy after 1978, comprising religious-owned hospitals financed by the state alongside a public system of healthcare. There are therefore important structural similarities between the Irish and Italian health services, and the balance between spending on public and private healthcare is also similar in these countries[7].

[7] The private provision of publicly-funded health care is also found in Spain, where health services are provided by either public institutions or private sector hospitals. The private non-profit institutions typically belong to the Church or to the Red Cross, although some are run by private foundations (Rodrigues, 1990). Just less than one-third of health care services are run by private bodies (Ibern, 1990), a little higher than the figures for Ireland (roughly 30%) and Italy (approximately 25%).

Figure 2.2 Non-Capital State Spending on Statutory Health Care in Italy



Source: Istat (various years), *Statistiche della Sanità*. Rome: Istat. (Values are constant, year 2000)

Despite these similarities, there are also differences between Ireland and Italy in relation to the structure and function of the health service. The absence of income thresholds and private health insurance from the post-1978 Italian health service signals one significant difference. However, the main difference between these two systems is in relation to their functioning. During the 1980s and 1990s, many Italian doctors used their position to construct a political *clientela* which could be exploited for electoral purposes. Della Porta (1993) points out that many Senior Consultants achieved promotion after 1978 as a result of their *political influence*, with the result that their careers came to depend less on their professional credentials than on their political connections. During the 'Tangentopoli' scandals of the early 1990s, an extremely high level of corruption involving the medical profession was uncovered. For example, the riches accumulated by Professor Duilio Poggiolini, General Manager of the *Servizio Farmaceutico del Ministero della Sanità* would be unthinkable without a generalised, self-interested consensus on the part of physicians, many of whom condoned the use of ineffective and at times harmful medicines (Traversa, 1994)[8].

[8] The *Corte dei Conti* has calculated that the flow of bribes paid by the pharmaceutical companies was in the order of 15,000 billion *lire* (or €7.7 billion) between 1983 and 1993. Pharmaceuticals accompanied by inadequate documentation came to represent roughly one quarter of gross pharmaceutical spending, which in 1992 amounted to 17,000 billion lire (almost 7 billion Irish pounds) (Traversa, 1994).

Criticism of political manipulation and clientelism within the health service increased during the 1980s, and this resonated with the neo-liberal policy proposals of the Liberal Party, Radicals and Republicans. These political parties proposed to replace the degenerate mechanisms of the public system with market mechanisms. The neo-liberal torch was taken up by *Forza Italia* and the Northern League in the early 1990s, and their crusade against the National Health Service received substantial public support. As I will show in Chapter Five, a number of nurses view market reforms as the most effective means of resolving the problems of the Italian health service, and this also influences union strategies. The relatively high level of support for market-based reforms in Italy is clearly related to the poor functioning of the public services in many areas of the country[9]. For example, Ferrera (1989) provides the following overview of the failings of the health service during the 1980s:

> *Expenditure decisions are decentralised to regional governments, local health units and, ultimately, to individual providers. Central government has virtually no capacity of planning and control and limits itself to footing the aggregate health bill.* (Ferrera, 1989: 128-9)

Even after 1990, when a penalty for overspending by regional governments was introduced (law number 334), this trend continued. The Regions appeared incapable of implementing spending restraint, reinforcing arguments for root-and-branch reform. Dissatisfaction with the health service was also widespread: almost 40 per cent of Italians stated at the end of the 1980s that they used an influential acquaintance to obtain access to health services or to ensure a superior quality of care (Censis, 1989). Cases of *malasanità* (scandals regarding medical negligence, poor service and low standards in the public health service) were frequently reported in the media, particularly in Naples. Most importantly, many Italians voted with their feet during the 1980s, resorting increasingly to private health care (for which they were forced to pay directly).

Health Policy in Italy, 1990-2000

The process of health service rationalisation began in Italy at the end of 1988, when the Government imposed reductions in health spending and increases in prescription charges. A fee of 10,000 lire (€5) was introduced for each of the first 10 days in hospital as well as a charge of up to 30,000 lire (€15) for diagnostic examinations. The Government aimed to cut public expenditure in light of a budget deficit of 148,000,000 million lire (€75 billion); the handicapped, pensioners and low income earners were exempt from the charges. As a result of a four-hour general strike, called jointly by the three Italian union confederations, the Andreotti Government withdrew some of the most controversial elements of the Budget. In September 1991, the Italian Government announced further cuts in spending (including a reduction of 35,000 in the number of acute hospital beds), and health charges were once again increased, triggering another four-hour protest strike.

A tripartite agreement was signed between the union confederations, employers' representatives and the Italian Government in July 1992 in a climate of financial crisis and institutional instability. This agreement covered the 'modernisation' of the public sector and of the machinery of collective bargaining and heralded the beginning of a strict policy of wage restraint (see Chapter Three, where I deal in detail with the 1992 Accord). As in Ireland in 1987, many commentators emphasised the risk of insolvency due to the scale of the public debt and the trend in employment levels. And in common with the Irish case, the pace of health service rationalisation increased dramatically after the national agreement was signed. An austerity package of roughly 94,000,000 million lire (€47.5 billion) was introduced in September, with the aim of cutting costs and raising revenues. This focused on pension entitlements, public sector pay, recruitment and health care. The main revenue-raising element of the package involved the abolition of free medicine and health care for those whose gross annual earnings exceeded 40,000,000 lire (roughly €20,000).

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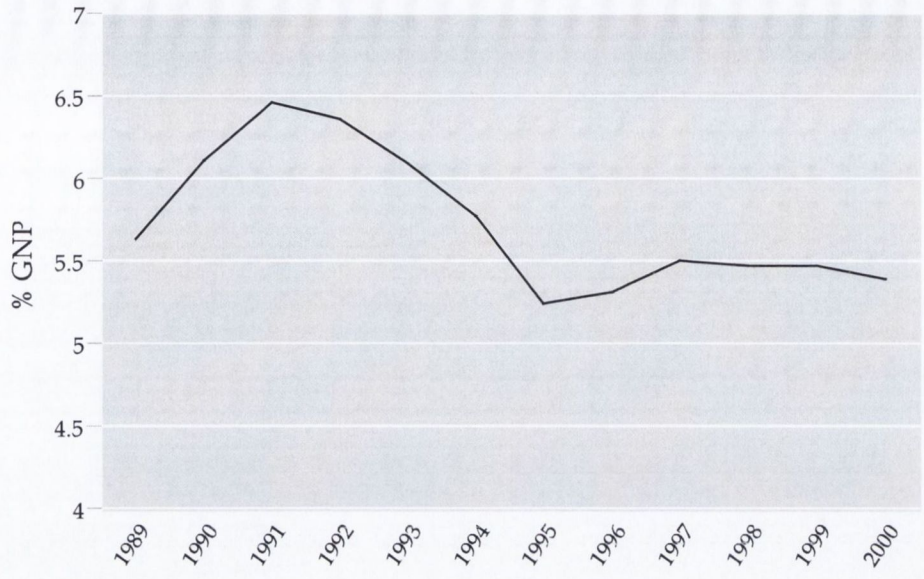
[9] It is important to stress that there are exceptions to this, most notable in Emilia-Romagna, where the Communist local administration based its reputation on the development of effective public services during the 1970s and 1980s, favouring the development of an efficient network of services.

In September 1993, further spending cuts of 28,000,000 million lire (€14.1 billion) were announced by the Treasury Minister and the ceiling for public sector pay increases was set at 2.5 per cent. The Budget announced a large number of redundancies in the public sector and renewed the embargo on recruitment. Prescription charges were increased and new charges for diagnostic procedures were introduced; a further reduction in the number of acute hospital beds was also announced (-0.5% per 1,000 inhabitants). The unions were consulted prior to the announcement of the Budget, although none of their suggestions were accepted. However, unlike previous years, no industrial action was taken. Once again, it is possible to draw parallels with the Programme for National Recovery in Ireland in 1987, as a series of severe budget cuts were announced after the conclusion of the agreement, and the union leadership chose not to actively oppose them.

As a result of the rationalisation of the hospital network after 1992, the number of public hospitals in Italy fell from 1,163 in 1993 to 941 in 1997. The number of hospital beds declined from almost 300,000 to just over 260,000 (a reduction of more than 13%). Nevertheless, the number of patients treated in public hospitals increased from 7,921,499 in 1993 to 9,086,396 in 1997, an increase of almost 15 per cent. The number of nurses and doctors working in the public health service increased by 10.6 per cent over the same period, although in Naples there was actually a decline of 3 per cent in the number of nurses and 2.5 per cent in the number of medical staff (Istat, 1996, 2000). I will discuss some of the consequences of these trends in Chapter Five.

Figure 2.6 Public Health Expenditure in Italy as a Percentage of GNP



Source: Istat (various years), *Statistiche della Sanità*. Rome: Istat.

A far-reaching package of health service reforms was passed in Italy at the end of 1992 (legislative decree 502/92), followed in 1993 by a series of amendments (legislative decree 517/93). At first reading, the reforms are radical in intent and promise far-reaching changes in the management of the health service. Their implementation according to a 'maximalist' interpretation would facilitate the growth of private hospitals, specialised in a range of interventions which, if successful in attracting patients away from the existing public facilities, would force their closure. Nevertheless, there are a number of ambiguities in the legislative provisions enacted in 1992-3. The balance between 'competition' and 'planning' is left to the discretion of the individual regions, and the limits within which local health purchasers can negotiate with providers are unclear. Although the citizen's freedom of choice between various public and private structures is asserted, it is not clear how 'freedom of choice' might conflict with the planning role allocated to the Local Health Units (*Aziende Sanitarie Locali*, or ASL). Furthermore, doubts have been expressed about how competition can take place between private and public hospitals. For example, the public hospitals must provide a full range of medical services, whilst private hospitals can 'cherry-pick' the most profitable procedures within the constraints imposed by the regional authorities.

The legislative decrees 502 (1992) and 517 (1993) introduce four key changes in the institutional configuration of the health service. Firstly, there is a further decentralisation of administrative and organisational responsibility to the Regions. Regional health budgets are funded mainly by the State in accordance with the magnitude and composition of the regional population. The Regions have the power to appoint the managers of Local Health Units (LHUs) and hospitals, replacing the role previously exercised by the *Comuni* (Local Authorities). The fact that financial shortfalls at regional level will have to be met via additional regional taxes introduces an incentive to avoid overspending and aims to curb the impunity with which the Regions accumulated deficits in the past.

Secondly, the LHUs – be they hospitals or district services – must adopt private-sector-style accounting procedures and management techniques, a process referred to as *aziendalizzazione*. This involves the creation of a strong and autonomous management team on private fixed-term contracts, with individual responsibility and performance-related pay. At the apex of the managerial hierarchy is the *Direttore Generale* (General Manager), who nominates a *Direttore Sanitario* (Health Director) to take charge of clinical matters and a *Direttore Amministrativo* (Accounting Director) to take charge of the administration of the hospital or Local Health Unit (LHU). In addition to this 'monocratic' structure, the new legislation states that autonomous hospitals and LHUs must adopt business-like accounting procedures, and similar conditions apply to each productive unit within the hospital or LHU (France, 1997: 76). The new system of funding, management and competition was introduced in 1995 and finalised at the beginning of 1998. Thus we are only now in a position to assess the impact of the reforms.

The General Managers of hospitals and Local Health Units are under an obligation to formulate a balanced budget, and receive a bonus depending on their performance in this respect. All health care providers must set up internal checks on the efficiency, economy and quality of the service they provide. They must also produce a Charter which specifies the services available to the public and an information service must be provided for service users. Individual employees are rewarded in accordance with their contribution to the 'profitability' of their enterprise (*azienda* – the terminology reflects

the privatistic style of the health reforms) and their contribution to service quality. However, alongside these incentives, the new legislation also stipulates that wards with an average annual bed occupancy rate of less than 75 per cent must close beds and those which fail to achieve an overall rate of 75 per cent must undergo restructuring.

The third dimension of change involves the introduction of 'managed competition' (*concorrenza amministrata*), the details of which are to be determined by the Regions. In general terms, this involves a system of remuneration negotiated between LHUs, autonomous hospitals and regional authorities, based upon a set of national guidelines. An element of competition – which varies from region to region – is created by the freedom of patients to choose between alternative service providers and by the purchasing role of the LHUs. Hospitals receive a block grant at the beginning of the financial year, negotiated on the basis of a specified number of treatments disaggregated by diagnosis-related group (DRG), and at the end of the year this grant is adjusted according to the actual number of patients treated. However, the DRG weighting is small (see below), as well as being subject to regional variation, with the result that the funding system in the Southern Regions remains heavily centred on historical spending levels.

The 1992-1993 reforms remove many of the remaining obstacles to the *public* funding of *private* hospitals which provide care within the ambit of the SSN. As I noted earlier, private hospitals were incorporated into the National Health Service after 1978 on the basis of contractual agreements. Although this was intended to provide additional capacity where public hospitals were unable to cope with the demand for treatment, this system of *convenzioni* was often abused (Vicarelli, 1996; Berlinguer, 1994). Under the new law, private clinics certified by the regional authorities are free to carry out a wide range of medical procedures and individual citizens are free, at least in theory, to have these procedures paid for by the state:

> *The LHU thus becomes primarily the purchaser of health services for its own clients within a health care market formed by existing providers, both public and private, between which the patient can exercise a completely free choice.* (Falcitelli, 1997: 15)

As I have already mentioned, the health service reforms have acquired specific regional characteristics in the course of their implementation. Policy analysts point out that this process has tended to restrict the notion of 'completely free choice' (France, 1997; Bariletti and France, 1995; Arcangeli and France, 1996). As far as regional differences are concerned, France (1997) focuses on two contrasting models: the model of the 'Local Health Unit as Third-Party Paymaster' and the 'Local Health Unit as Prospective Planning Body'. In the first model, private and public health care providers are remunerated on the basis of the procedures they actually carry out, and absolute priority is given to the freedom of choice of the patient. The LHUs have minimal planning responsibilities and concern themselves above all with calculating and controlling the payments to individual doctors, clinics and hospitals. The best example of this model is provided by the Lombard Region:

> *[The Lombard Region] has decided to impose a much more extreme interpretation of the 'market', largely equating public and private health providers and disregarding the need for planning and control over service provision...* (Corcione, 1998: 204)

The LHUs have a much stronger planning role in the second model, negotiating a prospective plan with a limited number of 'preferred providers' and developing long-term contractual arrangements. The current role of the Regions is concerned with the appointment of managers, the accreditation of hospitals and clinics, the negotiation of levels of service provision and health planning. Article 2 of the legislative decree number 502/1992 indicates that the Regions should establish "guidelines for the organisation of health services and health promotion, funding criteria for the LHUs and autonomous hospitals and technical support and assistance to the LHUs and autonomous hospitals". As the direct funding body for all public health care, the

Regions are responsible for determining the procedures that will be used to allocate the available resources and have a key role in monitoring service provision.

Alongside the health reforms of 1992-3, the legislative decree 29/93 abolished the special status of public employees and equalised the situation of public and private sector employees in relation to contractual bargaining and employment conditions. Further alterations and amendments were passed in the mid-1990s. A massive privatisation programme also began in 1992, and this year is often seen as marking the transition from the 'First Republic' to the 'Second Republic', as the effects of corruption scandals led to a reconfiguration of the party system.

Health Service Rationalisation in Ireland and Italy: A Comparative Analysis

Having provided an overview of the changes that have taken place in Irish and Italian health policy in recent years, I will now focus specifically on the nature of the 'rationalisation' process that has been implemented in these two countries. I use the term 'rationalisation' to refer to organisational and financial innovations that seek to improve the efficiency of public services or to limit public expenditure.

It is important to distinguish at the outset between two different forms of rationalisation. The first involves cuts in hospitals, beds or employees, as well as reductions in budgets and cuts in entitlements. The second involves organisational changes such as the creation of an autonomous management team, improvements in communication between wards or the maximisation of bed usage. Both types of initiative aim to improve efficiency, the first by reducing costs and the second by increasing output. Thus, when I refer to health service rationalisation during the 1980s and 1990s I am thinking specifically about these two types of intervention.

In both Ireland and Italy, an intense phase of cutbacks in beds, employees and budgets characterised the first two years of the rationalisation process (after 1987 in Ireland and 1992 in Italy). Although these cuts had a dramatic effect on patients and health workers (see Chapter Five), they did not interrupt longer-term trends in health service expenditure growth (see Figures 2.1 and 2.2). Perhaps in recognition of the difficulties

involved in maintaining tight control over health expenditure, the focus of rationalisation in both countries subsequently shifted to questions of efficiency, responsiveness and organisational effectiveness. Whereas the early stages of rationalisation brought an embargo on recruitment, a wage freeze, an increase in charges and the closure of small hospitals, subsequent interventions focused primarily on managers and markets as a source of continual improvements in efficiency levels.

These developments were not unrelated to the international context of health policy reform during the period in question. According to the OECD (1994) and the World Health Organisation (1996), the 1990s witnessed a massive wave of health service restructuring, with as many as 40 countries undertaking reforms during the early 1990s. As a consequence, the OECD (1992) argues that a paradigm shift occurred, away from the 'integrated public' model and towards the 'contractual public' model. Arguably the best way of theorising this shift is in terms of 'competitive state restructuring'. This refers to the pursuit of a competitive advantage by means of welfare policy innovations, and is exemplified by developments within the European Union (EU).

The process of European political and economic integration has conditioned policy debates throughout the EU, as government decisions have been strongly influenced by the strategic considerations of the 'core' countries. Although European producers strengthened their position vis-à-vis US capital during the 1960s, the recession of the mid-1970s put a halt to this 'productivity catch-up' (Albo & Zuege, 1999). Further crises followed during the 1980s and European competitiveness has been stagnating ever since. In fact, growth in GDP in Europe since the 1980s has been lower than in either of the other two regional blocs and unemployment rates have been considerably higher (Brenner, 1998). As a consequence, the process of European Monetary Union bears a neo-liberal stamp, and the monetarist and deflationary preferences of the core countries are evident from the contents of the Maastricht and Amsterdam Treaties.

The acceleration in state restructuring during the 1990s arguably represents a strategic response to the intensification of competition in world markets. Early policy 'innovators' such as the US, UK and New Zealand were scrutinised by policy-makers in other countries, and this seems to have triggered a chain-reaction of 'competitive

restructuring' throughout the advanced capitalist countries. A small number of policy models have dominated debates, and these have been promoted by bodies such as the influential Public Sector Management Service (PUMA) of the OECD. PUMA argues that traditional public service management approaches are outdated because 'highly centralised, rule-bound, and inflexible organisations that emphasise process rather than results impede good performance' (OECD, 1995: 7). The OECD also evokes the virtues of private sector managers, arguing for the devolution of responsibility from the centre to local level and for the *artificial* creation of competitive pressures if necessary:

> *Apart from distortions introduced into the market economy as a result of financing public provision, there has been heightened concern about possible inefficiencies in public production stemming from the absence of 'disciplining' market mechanisms, notably the absence of bankruptcy and takeover threats to management and of competitive pressure.* (OECD, 1989)

There are three dimensions to the model of New Public Management advocated by the OECD: managerialism, organisational change and marketisation (Hood 1991; Dunleavy and Hood 1994). 'Managerialism' seeks to increase the autonomy, accountability, effectiveness and authority of health service managers, whilst using performance targets, appraisal and incentives to encourage 'efficient management'. This is often justified in terms of the implementation of private sector models of best practice. The specific forms of organisational change advocated include the creation of more 'functional' devolved units with budgetary and operational responsibility in the context of a decentralisation of decision-making and financial accountability. Finally, 'marketisation' expands the scope for competition within public health systems by using contractual arrangements to regulate service provision.

Policy analysts have suggested that the increased speed and volume of international communications encourage the diffusion of policy models and favour convergence (Björkman & Altenstetter, 1997: 1, 3). In relation to the latter, Freeman & Moran (2000) argue that by the 1980s, "common or at least comparable solutions to health policy problems began to be drawn from a general, international currency of reform ideas". As a result, according to Corcione (1998), the health care systems of many

advanced countries have begun to converge on a common model. The basis for this convergence is the retreat of universalistic welfare states from comprehensive care and the gradual extension of the coverage of public insurance systems (Corcione, 1998: 178). Thus, this process of convergence is often linked with the popularity of the 'contractual public' model, which figures centrally in OECD publications (cf. Freeman & Moran, 2000: 42).

Although it seems likely that European policy-makers have been influenced by these models, a number of tendencies obstruct any straightforward process of policy convergence across the EU as a whole. Firstly, the preference for a consensual approach in many EU countries favours incrementalism and slows down the pace of change. Secondly, existing administrative traditions and institutional forms tend to 'contaminate' new policies, however radical they may seem (this process is often referred to as 'path-dependence'). Finally, the implementation of new models is dependent upon the agency of managers and administrators, and the latter therefore have the capacity to block reforms. As I will show in Chapter Four, hospital managers often have commitments to existing institutions as well as vested interests that provide alternative forms of 'managerial rationality' in opposition to imported policy models.

Although it would be difficult to find convincing evidence for a European-wide process of policy convergence in relation to the health care system, it is nevertheless possible to detect more limited forms of convergence within specific areas. As I have shown in this chapter, for example, the experience of state restructuring in Ireland and Italy provides evidence of a degree of convergence within the 'peripheral' countries of the EU. There has also been a considerable convergence in relation to the health expenditure of European countries over the last twenty years, again with recognisable clusters. In 1980, Ireland's expenditure on public health care relative to national output was third among EU states, at 8.7 per cent of GDP. Since 1993, however, the only member states to spend a smaller proportion of GDP are the UK, Luxembourg and Greece. This stands in marked contrast to the expansion that occurred in the Southern European periphery during this period. For example, Greek spending on health care relative to GDP increased by almost 90% between 1980 and 1996, followed by Portugal (43.1%) and Spain (32.14%) (Wiley, 1998). The rate of increase in real spending in Italy was much

lower (11.43%), but this nevertheless contrasts with the Irish decline of 19.54%. However, it is important to note, as I mentioned earlier, that rapid economic growth inevitably compresses GNP-based measures of health spending.

Only two other European countries reduced spending as a percentage of GDP over this period: Denmark (-8.05%) and Sweden (-8.51). As these countries were near the top of the European rankings in 1980, this reduction suggests that there may have been a degree of convergence in health spending relative to GDP during the 1980s and early 1990s. Whereas the percentage of GDP spent on health ranged between 3.6 per cent (Greece) and 9.4 per cent (Sweden) in 1980, it varied between 6.8 per cent (Greece) and 10.5 per cent (Germany) in 1996, with most countries clustered around 8 per cent.

In the following sections I will provide a comparative analysis of recent changes in the management and organisation of the Irish and Italian health services. As the ideas associated with New Public Management have been particularly influential, I will structure my account around the three core motifs of this model: managerialism, organisational reform and marketisation (Bach, 1999; Hood 1991; Dunleavy and Hood 1994).

Health Service Rationalisation: Managerialism

In relation to managerialism, there have been more radical changes in Italy than in Ireland, although there has been an increase in the responsibility and accountability of management in both countries. In Italy, legislation has created a relatively autonomous General Management function in the large acute hospitals and in the Local Health Units. In relation to personnel, managers are expected to operate with the 'same capacities and powers as private employers' (legislative decree number 29/93, article 4). This may include the reorganisation of individual roles, the definition of workloads, the organisation of working hours, internal mobility, the hiring of employees on temporary contracts and any other decision geared towards improving productivity (D'Orta, 1995; Bordogna et al., 1999: 107-8). In Ireland, the Health (Amendment) Act 1996 has given the Chief Executive Officers of the Health Boards greater powers and responsibilities. More importantly, normative models of health administration have been reformulated

by virtue of an ideological offensive which concentrates on the authority, cost-accounting rationality and strategic outlook of management. This has embraced the public administration as a whole and represents a major attempt to reshape the activities, role and self-understandings of public managers (see Chapter Four).

Health Service Rationalisation: Organisational Change

In terms of organisational change, the relative autonomy of the 83 autonomous hospitals represents the most important innovation in Italy[10]. Were this process to continue, leading to the removal of the remaining 1,000 hospitals from the direct control of the Local Health Units, this would have a massive impact on the Italian health service (Mapelli, 1996: 199).

The shift in executive responsibilities from the central state to the Regions is central to the Italian reforms, and this has paradoxically been accompanied by tighter central controls on spending. This innovation may be compared with the changes that have occurred in the role of the Health Boards and with the creation of the Eastern Health Authority in Ireland. Similarly, the emphasis on 'agreed service levels' in Ireland may be compared with the Regional Health Plans in Italy, which aim to integrate different kinds of health care provider into a coherent whole. The distinction between policy-making (Department of Health), executive decision-making (Health Authority) and health care provision (Health Board and Voluntary Hospitals) in Ireland also resembles the structure of the Italian health service, although the division between funders and providers is rather blurred in both cases. Although organisational change has been less radical in Ireland, this may be attributable to the high level of autonomy that already characterised the Voluntary Hospitals.

[10] These hospitals may be compared with the Trust hospitals in the British NHS and the Voluntary Hospitals in Ireland.

Health Service Rationalisation: Marketisation

Turning now to marketisation, there is a sharp contrast between the strong emphasis on managed competition in the Italian reforms and the lack of attention to market mechanisms in Ireland. For example, Jerry O'Dwyer, Secretary-General at the Department of Health and Children, states:

> *It is reasonable to assume that changes in structures will not be driven by any particular ideology and that the market model will not be adopted. It is much more likely that changes in structures will be evolutionary, based on experience and evidence, responding to an agenda which is primarily dominated by the requirements of health strategy, formulated in accordance with overall government policies.* (O'Dwyer, 1998: 38)

Ireland's small population may reduce the relevance of market-based reforms: "the sheer size and the urban/rural spread of the Irish population could hardly offer a sufficient market for a competitive system of HMOs" (NESC, 1990: 266). However, this is not such a sharp contrast as it may appear at first, as the implementation of the new health legislation in Italy has tended to dilute the role of competition. Moreover, the Irish system already incorporates forms of competition between the public and private sectors due to the existence of a public insurance scheme. In this context, it is worthwhile recalling Freeman & Moran's cautionary comments:

> *Competition ... perhaps the signal term in the international discourse of reform, may well turn out to have been one of the more transient. In the UK, where it was promoted most vigorously, and in Sweden, competition has turned relatively quickly into collaboration between larger units with more clearly defined functions of planning and providing care.* (Freeman & Moran, 2000: 55)

In Italy, the introduction of a model with many similarities to the NHS reforms in Britain occurred in 'adverse circumstances' (Bach, 1999), with the result that "attempts to 'empower' management have been constrained by the continuation of an all-encompassing framework of administrative and legal regulations with rules defining

personnel policies such as recruitment and promotions" (Bach, 1999: 93). The rhetoric of the market has remained a chimera. In Ireland, the incremental restructuring of a strongly 'dualistic' health service in the context of severe spending constraints during the late 1980s has generated a similar 'modified neo-liberal solution' encompassing market elements as well as a form of integrated public service[11]. Not only does competition have a comparable weight within the Irish and Italian health systems, its role is formalised by means of the same funding mechanism – casemix measurement using diagnosis-related groups, which will be the focus of the next section.

Health Service Rationalisation: Casemix Funding Mechanisms

Casemix funding mechanisms based on diagnosis-related groups (DRGs) are central to the rationalisation of public health care in Europe. It is therefore worth discussing this rather technical issue and evaluating its consequences. Casemix measures represent a clear example of policy diffusion:

> *Too often, technology transfer is taken to refer to items of capital equipment which can be crated and shipped overseas. Recent experience would suggest, however, that certain concepts, tools and techniques may also travel well, particularly if they are amenable to adaptation to the local environment.* (Wiley, 1992: 1)

The evolution of the Irish funding system centres on the development of "a resource allocation system which would link hospital budgets to the type and volume of services to be provided" (*Review Body on Higher Remuneration in the Public Sector*, 1990: 33). Wiley and Fetter conclude their 1990 study by suggesting that the DRG system could be used to this effect, enabling the Irish health service to overcome the inefficiencies which the *Commission on Health Funding* identified in relation to the previous system of global budget allocations. Originally developed in America and introduced by Medicare

[11] As noted above, the similarities between the Irish and Italian health systems are linked with their distinctive experience of late and uneven development in the European periphery. If a complementary system of subsidised private health insurance for the middle classes were to emerge in Italy in the near future, the structural similarities between the two countries would be striking. Nevertheless, the Irish and Italian health services are also quite different: in terms of their relationship with the wider society, their 'ethos', the relationship between health workers and patients and the level of managerial compliance with health policy.

in 1983 as part of its Prospective Payment System (PPS), the DRG system has been researched and supported by the OECD (OECD, 1992), Council of Europe (Rodrigues et al., 1988), European Community (EURODRG, 1989-1992) and World Health Organisation. Case-mix measures use medical data to guide resource allocation and, by permitting the identification of costs at sub-hospital level, they provide a definition of the 'output' of each division.

Each diagnosis-related group classifies cases in terms of the amount of treatment they entail and the material and organisational resources they require (Fitzgerald & Lynch, 1998: 30-31). In 1993, the Irish Department of Health used casemix measurement for the first time, although its effects were limited to just fifteen hospitals. The system was extended to include twenty-one hospitals in 1994, twenty-three in 1995 and twenty-six in 1996, eventually covering all large hospitals. The 'blend rate' was increased gradually, reaching 15 per cent in 1996. This does not imply a variation of 15 per cent, but merely means that 15 per cent of hospital in-patient costs are adjusted by reference to their casemix-measured performance[12]. In actual fact, the year-on-year adjustments are relatively small in comparison with overall budgets (although some acute hospitals have suffered a reduction in the region of 1% in their budgets). However, because the system has cumulative effects (adjustments are incorporated into the following year's allocation), the effect of casemix budgeting over time can be considerable.

Hospitals are expected to respond to cuts in their budgets by examining their cost structure and by analysing activity patterns. However, the amount of financial and strategic planning that has been undertaken in acute hospitals in Ireland has so far been modest:

[12] Costs are assigned to selected 'cost centres' on the basis of either length of stay (e.g. physician costs) or a series of service weights (for laboratories and pharmaceuticals). Hotel costs are assigned using a combination of length of stay and service weights. A 'casemix index' is calculated for each hospital by applying a relative value to each DRG and taking the weighted average of these values according to the number of interventions in each category. The relative values represent the national average for each DRG relative to the 'average DRG'. This facilitates analysis of relative cost performance at hospital and even sub-hospital level.

> *The analysis of service effects indicated that, for the most part, the positive and negative budget adjustments did not result in changes in the level of service provided: hospitals with significant positive adjustments did not increase activity levels, but instead used the additional funds to offset deficits arising from other sources. Hospitals incurring negative adjustments maintained existing service levels in each year covered by the study, by the use of development funding and equipment replacement monies.* (Fitzgerald & Lynch, 1998: 44)

Although casemix measurement appeared to have created greater awareness of costs and the length of patient stays, this did not translate into measurable efficiency gains in Ireland (Fitzgerald & Lynch, 1998; Wiley, 1992). Arguably, this is attributable to the low weighting assigned to the casemix index, a key consideration. In fact, in both Ireland and Italy, it is evident that the political will to impose a fully-fledged casemix budgeting system has been lacking. Casemix funding sets up a system of material incentives which are intended to stimulate strategic management. However, this system of incentives may come into conflict with existing institutional logics. For example, hospital managers may prefer to cross-finance losses from alternative sources of income rather than making cuts. Before resorting to bed closures or a fundamental reorganisation, managers are likely to adopt a more 'aggressive' approach to the classification of patients (Fitzgerald & Lynch, 1998) and to exploit loop-holes in the system (Donaldson & Magnussen, 1991).

In order to have an effect, casemix funding mechanisms must penalise relatively costly hospitals, a step which is politically unacceptable in the absence of a severe economic crisis. For example, there is evidence that the Irish Department of Health 'rescued' hospitals which had lost funding due to the DRG system by providing additional capital equipment funding or development grants (Fitzgerald & Lynch, 1998). Similarly, Regional administrations in Italy have, at least in some cases, diluted the impact of this system.

Health Care and the Market

Adopting a broad perspective on health care reform in Europe, one aspect of the recent wave of reforms that demands explanation is the rejection of the 'integrated public' model. This model is based on universal coverage through compulsory participation, comprehensive benefits, the payment of contributions which are proportional to income and cost control through administrative mechanisms. Comparative policy analysts have shown that this model is superior to market-based systems in terms of equity, cost efficiency, efficacy and quality (cf. Evans, 1998; NESC, 1990). The 'internal market' in health is *not* a cost-saving innovation: spending on health in the UK accelerated rapidly after the introduction of market reforms and the US case provides an even more clear-cut example of the consequences of market-based health care provision:

> *...the American approach is by international standards grossly inefficient, heart-breakingly unfair, monumentally top-heavy with bureaucracy, and off the charts in both the level and the rate of escalation of costs.* (Evans, 1998: 19)

Given this evidence, support for market-based alternatives must be explained in terms of the interests of social class actors. Tax-financed schemes are inevitably more 'progressive' than systems based on private insurance because tax liabilities tend to be proportionate to income; illness is not. Moreover, private insurance is independent of income, with the result that lower-income individuals tend to pay a larger share of their income for the same coverage. This also applies to service charges and co-participation fees. Although these are often justified by arguing that they encourage 'responsible' utilisation of health care, the main point is that "shifting the cost burden from taxpayers to users will on average redistribute wealth from lower to higher income individuals" (Evans, 1998: 37-8). In addition, market mechanisms yield higher prices for physicians, drug companies and private insurance companies, ensuring their support for reforms. In electoral terms, the middle classes tend to gain from the introduction of private insurance as they can purchase a higher quality and more timely service for themselves without having to support a similar standard for others.

In this context, the repeated insistence by Irish policy analysts that the existence of a private insurance scheme does not detract from the benefits of a publicly-funded health service should be subjected to close scrutiny. For example, the Commission on Health Funding (1989) argues that "the choice at issue is that of a *main* funding model; a predominantly public funding system can be supplemented by private arrangements, or vice versa" (p. 8). Similarly, NESC (1990) argues that private health care should continue to be subsidised in public hospitals, as the income from private care contributes to the income of the public hospitals.

The importance of providing a clear analysis in relation to this issue is underlined by the failure of the Irish government to implement two key recommendations contained in the report of the Commission on Health Funding. Firstly, the Commission argued that the VHI (insurance) system should only be continued on the condition that tax relief on private health care be abolished and that private patients be forced to pay the full cost of their treatment. In the absence of such regulations, members of the Commission expressed concern that private patients could simply combine a public bed with private specialist care: "patients should have to make an explicit choice between public and private hospital care and should not be able to combine the two... Those opting for private care should meet the full cost of treatment" (p. 11). Secondly, the Commission insisted that:

> *An objective system of assessment for access to public hospitals should be introduced for all planned (as opposed to emergency) admissions, involving a common waiting list for both public and private patients, from which cases would be taken in order of medically-established priority.* (Commission on Health Funding, 1989: 19)

This proposal is perfectly consistent with the 'mission statement' of the Department of Health, which emphasises 'equity' as one of the key aims of the health service. This principle was restated in the 1994 'Health Strategy'. Although tax relief on private health care has been reduced from the marginal to the standard rate, no other action has been taken on the above proposals. Most seriously, the unions have entered into five successive national agreements without insisting on an end to the system whereby

public patients are forced to wait months for treatment whilst private patients are typically only inconvenienced by a matter of days.

Summary

In this chapter I have described the evolution of health policy in Ireland and Italy over the last two decades, concentrating on the rationalisation of health care during the 1990s. I provided a brief overview of the 'new public management' in Europe and evaluated the Irish and Italian health reforms under the headings of managerialism, organisational change and marketisation. Under each of these headings a number of significant similarities are evident in the two national case studies. Moreover, health service rationalisation occurred against the backdrop of severe economic and fiscal crises in both countries, comprising an initial phase of cuts followed by reforms of a more 'structural' nature. Casemix funding mechanisms play a key role in this process of rationalisation, as they facilitate a form of 'managed competition' between different service providers. Nevertheless, the reluctance of the Irish and Italian governments to implement anything but a 'soft' version of managed competition within the public health service is indicative of the difficulties faced by all attempts to structure health care provision in terms of market competition (Evans, 1998).

III UNION RESPONSES TO HEALTH SERVICE RATIONALISATION

Introduction

In Chapter Two I provided an overview of the changes that were implemented in health policy in Ireland and Italy during the late 1980s and early 1990s. I argued that the resulting process of rationalisation took the form of a competitive restructuring that drew inspiration from the neo-liberal policy models promoted by international organisations such as the OECD. Nevertheless, the legacy of late and uneven industrial development in Ireland and Italy has given rise to a distinctive process of health service rationalisation in which 'modified neo-liberal solutions' are implemented within a neo-corporatist structure of tripartite agreements.

In this chapter, I will explore how union involvement in concertative bargaining arrangements emerged in Ireland and Italy towards the end of the 1980s and I will ask whether the unions' participation in national agreements influenced their responses to health service rationalisation. I will pay considerable attention to the distinctive positions adopted by different union actors, relating these to their institutional structure, political affinities, cultural inheritance and ideological outlook. This will involve a comparative historical analysis of the evolution of the Irish and Italian union movements. I will then discuss neocorporatism and discuss modifications to and criticism of the original version of this theory. This will provide a framework for the empirical analysis of union responses to rationalisation that follows in the second half of the chapter.

Methodological Considerations

Because a relatively coherent and concentrated programme of health policy 'reform' was pursued in both countries during the period in question, I will confine my attention to union 'responses'. Obviously, the positions adopted by unions are not only 'reactive' but may also be 'proactive' in nature. In order to take account of this factor, I will situate the unions' responses to rationalisation in relation to the policy positions they adopted during the late 1970s and early 1980s.

The analysis of union responses raises questions about the strategic orientations of union leaders, the internal distribution of power, the interpretation of complex patterns of behaviour and the contingency of observed outcomes. The most important attribute of union organisations in this sense is their complex institutional structure and relatively formalised decision-making procedures. Whereas senior managers often avoid giving direct expression to their strategic objectives in order to maintain flexibility (see Chapter Four), the relationship between union representatives and their members necessitates a much more transparent decision-making process. The fact that key aspects of union policy must be discussed in the public domain, and that the resulting decisions are published in union journals and newspapers obviously makes the job of the researcher somewhat easier.

However, it remains the case that individual actors and organised groups within the unions may pursue strategies that are at odds with official union policy, and these internal differences may give rise to contradictions in relation to the positions and actions of the unions. Moreover, official statements of union policy are frequently rather generic in nature, and the real priorities of union leaders may at times be camouflaged by rhetoric designed to satisfy their constituents. Finally, the actual behaviour of union actors betrays a high level of selectivity in relation to various aspects of official policy, implying that it is important to examine what these actors *do* as well as what they *say*.

The discussion that follows is based on documents produced by the unions themselves and on reports published in industrial relations journals between 1987 and 1999, primarily the *European Industrial Relations Review*, the Irish journal *Industrial Relations News* and *Nuova Rassegna Sindacale*. A comprehensive literature review was

also carried out, embracing English and Italian-language publications. In addition, thirteen interviews were conducted by the author with national and regional union officials in Ireland and Italy between 1997 and 2000. The interviews were loosely structured and had an average duration of approximately two hours, during which time the views of union officials in relation to health service rationalisation and national agreements were solicited. All interviews were recorded and subsequently transcribed in full. In some cases, a brief 'off-the-record' discussion supplemented the recorded interview, whilst in others the distinction between 'on-the-record' and 'off-the-record' statements remained implicit. The willingness of the interviewees to speak openly about their role and to express a frank opinion in relation to government decisions and union policy clearly reflects their trust in the researcher, and every attempt has been made to reciprocate this trust (see Appendix B for a detailed description of the organisation and analysis of the interview transcripts).

When studying the positions, policies and actions of union actors, it is necessary to situate these within the context of their historical, political and cultural development (Lange, Ross & Vanicelli, 1982). Rather than viewing unions as "historical objects created and battered about by exogenous forces", Lange, Ross & Vanicelli (1982: 218) argue that unions should be approached as "agents with their own ideas, needs and purposes". For this reason, I will begin by providing a brief account of the post-war evolution of the Irish and Italian labour movements.

Historical Development of the Irish Union Movement

Throughout the post-war period, the key difference between the Irish and Italian labour movements was based on the distinction between the Anglo-Saxon model of the *craft trade union* and the model of the *party-ancillary union movement* found in a number of continental countries (Martin, 1989). The Anglo-Saxon trade unions originated in the last century, prior to the emergence of social democratic parties, and are generally characterised by a fragmented structure of representation that mirrors occupational and status differentials within the labour process. A contrasting influence within the Irish labour movement was provided by syndicalism, in the form of James Connolly's Irish Transport and General Workers' Union (ITGWU). Dismissive of political parties, the

ITGWU aspired towards comprehensive union organisation and a defence of the interests of the working class as a whole (Roche, 1997: 4-5). Both of these traditions – craft trade unionism and general unionism – encouraged the development of well-rooted workplace structures, most notably in manufacturing industry and transportation. However, when we look at unionism in the public services, the above pattern is reversed, as unionism in this sector has generally remained rather centralised in Ireland.

The Irish union movement emerged from the Second World War in a weakened state due to the contraction of the industrial economy and the divisions between the Irish-based and British-based unions. Wage levels remained low during the late 1940s and 1950s and the economic protectionism that had characterised the 1930s remained dominant. As in Italy, the political elections of 1948 mark a watershed in the consolidation of conservative government in Ireland (Girvin, 1994: 124), and this was associated with the consolidation of corporatist structures (Allen, 1997). In fact, in both Ireland and Italy, in contrast with many other European countries, the involvement of the labour movement in corporatist structures at national level may be traced to the early Twentieth Century.

By the time the rival union confederations merged to form the Irish Congress of Trade Unions in 1959, the political and economic landscape had changed considerably. As I noted in Chapter Two, the Taoiseach (Prime Minister) Lemass won support for a shift towards economic planning, the extension of state involvement in development and an opening up of the economy to foreign investment in 1958. Allen (1997) argues that this strategy coincided with a period of experimentation with social partnership arrangements, as Fianna Fáil sought to rebuild its earlier hegemony over the working class. As a result, union leaders became involved in a range of tripartite committees and commissions. This development was encouraged by the need to involve the union movement during the implementation of the new model of development:

> *...a variety of practical measures were also required both to raise productivity and to rationalise Irish industry if the Irish economy was to survive in free-trade conditions. In brief, Fianna Fáil established a number of institutions which sought to organise the unions, employers and the government around social partnership*

arrangements. This strategy aimed at further reform of the unions to ensure that they established discipline over their own members, and was part of a push towards greater productivity and flexibility. (Allen, 1997: 121)

The Historical Development of the Italian Union Movement

The Italian labour movement emerged from the Second World War in a state of considerable weakness, and the period immediately following the war posed further challenges for the unions. The *CGIL Unitaria* (formed by Communist, Socialist and Catholic political currents during the Resistance) gave way to three distinct union confederations after the secession of the Catholic component (which formed the CISL union) and the creation of a third, 'Socialist' union (the UIL) in the late 1940s. In the political, social and economic context of post-war Italy, these divisions – and the exclusion of the Communist Party from participation in the ruling coalition – facilitated the emergence of a 'party-ancillary' union movement characterised by close and enduring links between the principle union actors and the dominant political parties (Martin, 1989)[13].

The extreme centralisation of union representation – a legacy of the Fascist period[14] – left a vacuum of representation at workplace level that was only partially filled by the *Commissioni interne* (elected work councils without bargaining rights) and local branches of the Communist Party. This centralisation was reinforced by the particular emphasis that the largest union, the CGIL, placed on national solidarity, unity and the defence of employment levels. These priorities were largely conditioned by the precariousness of the economic and political structures of the new Italian Republic, but the ideological outlook of the Italian Communist Party (PCI) also played an important

[13] Martin argues that "Party-ancillary movements are a function of centrifugal pressures involving an intensity of ideological antagonism sufficient to override centripetal, unifying pressures arising from common interests defined by such things as occupation, industry, or class – or, as in India during the 1930s, by a struggle for national independence. This kind of polarisation within a trade union movement reflects, and appears to be primarily a function of, polarisation within the political system at large" (1989: 229).

[14] In 1925, the Fascist regime abolished the *Commissioni interne* and obliged the employers' federation to bargain directly with the Fascist Trade Union Federation. In 1927, a Labour Charter was enacted which expanded the role of the state in regulating industrial relations, and by 1929 the fascist unions had became mere organs of the regime (Contini, 1985).

role in this. During the mid to late 1940s and early 1950s, the PCI was preoccupied by the spectre of authoritarian rule, and feared the onset of a severe economic crisis[15].

These factors generated a considerable antipathy on the part of the CGIL towards localised or sectional forms of industrial action, which were considered 'divisive'; the other two union confederations did not mount a serious challenge to this model of union representation until the late 1950s. Strong workplace structures of union representation only emerged in the private sector during the late 1960s, although local union organisation emerged in some areas of the public sector as early as the late 1950s. Bordogna (1994) points out that a high level of informal union regulation of internal labour markets and working practices prevailed in the Italian public sector during the 1960s and 1970s, associated with 'autonomous' unions operating outside the auspices of the historic confederations, despite the formal centralisation of the collective bargaining system.

During the 1950s, the moderate CISL confederation began to re-evaluate the role of plant-level union representation as it sought to develop its own distinct identity. As the Communist-led CGIL asserted itself as a centralised, class-conscious, and political union, the CISL chose to model itself on the North American unions and become an autonomous, associational union, emphasising plant bargaining, productivity-linked pay and the reconciliation of workers' and employers' interests (Zoll, 1978: 138). Many of the CISL activists who passed through the union's cadre school in Florence during the 1960s expounded a more radical version of this model, arguing that the unions should work to keep wages in pace with, or even above, productivity growth in order to force employers to invest in new technology. However, the structural weakness of the Italian working class during the 1950s, and the fact that the CISL union as a whole lacked independence from employers, meant that this remained a largely theoretical programme, and when decentralised bargaining in industry finally took shape in the

[15] The strategic outlook of the CGIL in the 1950s was strongly influenced by the Italian Communist Party's analysis of the political conjuncture, which emphasised the need for alliances with 'progressive' political forces in order to avoid polarisation and to reduce the risk of a right-wing political coup (Lange et al., 1982). This was linked with the PCI's economic analysis, which was characterised by 'crisis catastrophism': Italian capitalism was 'trapped' in a cycle of economic decline as a result of the dominance of monopoly capital. Consequently, the CGIL attached overriding importance to the defence of employment levels at the expense of wage gains.

early 1960s, the CGIL had also begun to reconsider its stance in relation to workplace representation[16]. Contini (1985) provides a useful summary of these trends:

> *The favourable trend in the labour market and the growing militancy on the shop floor coincided with a gradual rapprochement between the Catholic and Communist wings of the labour movement and an increased willingness on the part of the unions to support the emergence of new bargaining structures in the factories. Thus the CISL began to abandon its Catholic organicism in the face of the strikes of 1962-3 which undermined a consensual interpretation of plant bargaining. Similarly, the recession of 1964, which rolled back much of the ground gained during the previous two years, demonstrated to the CGIL the urgency of a direct union presence in the factory, and the union began to moderate its hypercentralised bargaining strategy, while maintaining its previous radicalism. The project of establishing union sections in the plant remained theoretical through most of the 1960s, and the old* commissioni interne *continued to serve as the basic structure of worker representation in the factory. But despite the relative immobility of the leadership, the new union officials and the* commissioni interne *were collaborating more and more.* (Contini, 1985: 206)

Union Struggles in Italy During the 'Hot Autumn'

The cycle of industrial struggles in Italy between 1968 and 1972, which reached a peak in 1969 (the so-called *autunno caldo*, or 'hot autumn') introduced a number of important changes to the industrial relations system. Between 1968 and 1970, militant struggles involving semi- and unskilled factory workers in the North of Italy were led by rank-and-file workers, who created new workplace structures to co-ordinate their actions. The election of workplace representatives (*delegati*) was the main innovation: "We jumped on to the tables in the dining room and organised assemblies and the first strikes. In these strikes, we discovered the organisational instrument which then became the *delegato*; their election was direct, and the most militant comrades were

[16] This process had begun in 1955, when the CGIL lost the majority of seats on the works council at Fiat due to its perceived distance from the concerns of metal workers.

nominated"[17]. The *delegati*, who were typically linked with a specific area of the production process, came together in the *Consiglio di fabbrica* (factory council). This organisational form seems to have developed from the strike committees that emerged spontaneously in a number of Northern factories during 1968 and spread rapidly:

> *The* delegati *replaced the old, decrepit shop-floor structures of representation that were incapable of renewal or of taking over the leadership of a spontaneous movement. In the workshops that formed the vanguard of the conflicts in the 'Hot Autumn', the workers themselves came to the conclusion that the conflict that they would carry out would have to be strengthened by a more precisely articulated structure of representation on the shop floor.* (Zoll, 1978: 148)

During their national conferences in 1969, the Italian confederations (CGIL, CISL and UIL) sought to come to terms with the strike wave, which had until then unfolded in spontaneous fashion. The unions realised that if they did not intervene, they risked being sidelined. In fact, the confederations took the relatively bold step of incorporating the rank-and-file *Consigli di fabbrica* into their own representative structure, the federative pact signed by the three unions facilitating a unitary structure of representation at workplace level. Accornero (1992) provides the following account of these events:

> *As is widely known, the initiative that gave life to the* Consigli *was taken autonomously by the rank-and-file, although many union militants in the factories favoured this development and some even participated in it. After excruciating but understandable hesitations, lasting more than a year, that substantial innovation received a dual confirmation. Firstly, there was the 'constitutional' recognition by the* Statuto dei lavoratori[18] *of workplace union structures, convened by 'the most representative confederations', with distinct but equal rights to hold assemblies, to take time off work for union duties, to establish union offices and to hold referenda. There was then the 'political' recognition, on the part of the three confederations, of the delegates and their* Consigli *as a unitary workplace union structure, their*

[17] Excerpt from an interview conducted by Fabrizio D'Agostini with a workplace delegate (quoted in Zoll, 1978).

extension: this recognition reconciled associationism and movementism. (Accornero, 1992: 220-1)

The 'reform strategy' followed by the Italian unions during the early 1970s had its roots in negotiations over pension entitlements in the late 1960s. In late 1967 and early 1968, the unions conducted talks with the government in relation to a proposed reform of the pension system. A general strike was proclaimed by the CGIL in protest at the slow progress of negotiations, and, although CISL and UIL did not officially participate, the strike was supported by many of their local branches and federations. The success of the strike enabled the unions to negotiate an improved deal and this helped, in turn, to revitalise the union movement on the eve of the upturn in class struggle. During the 1970s, strikes were called over the use of armed police and to demand investment in the underdeveloped South, a National Health Service, improved housing and greater justice in the tax system. By bringing the strike weapon to bear on issues such as these, the unions sought to usurp the traditional role of the reformist political parties, setting themselves up as the most faithful expression of working-class interests.

By focusing on high-profile, national-level reforms, CGIL, CISL and UIL were able to overcome the initial fragmentation produced by rank-and-file militancy. This strategy enabled the leadership to regain control over the mass movement, reserving for itself the role of orchestrating mass protests (Regalia et al., 1978: 134). This involved a delicate process of leading industrial struggles whilst simultaneously restraining the militancy of the membership. The 1970 *Statuto dei Lavoratori* (Workers' Statute) helped the union leadership to regain control over workplace representatives by providing a set of legal regulations governing workplace unionism (Contini, 1985: 210).

In this period, the term *sindacato di classe* ('working-class union') gained currency. This refers to a distinctive model of union action based on unity between the three confederations, their alignment with the militancy of the mass movement and their pursuit of an expanded bargaining agenda embracing political reforms as well as economic demands. Lange et al. (1982) describe this model as consisting of "an attempt

[18] The *Statuto dei lavoratori* gave union representatives the right to time off from work with pay, to hold assemblies, to put up union notices in the workplace and to workplace facilities.

to combine the achievement of both transformative, classist political objectives and of associational, defensive, shopfloor objectives by acting simultaneously in the political and market arenas" (p. 98). As I will show later, this model continues to exert a powerful influence on the 'rank-and-file' unions (*sindacati di base*) and the collective memory of the 'hot autumn' has been incorporated into an oppositional political tradition that frequently emerges in the context of workplace unionism (see Chapter Six).

The *autunno caldo* was primarily a movement of industrial struggle, and the strike wave reached its highest point in the more developed North of Italy; the new union structures did not develop to the same extent in the South and in the public sector. In fact, the diffusion of *Consigli di fabbrica* outside the North was due primarily to union policy after 1970 rather than to rank-and-file initiatives. Nevertheless, the militancy of 1969 found an echo in many areas of public service employment during the 1970s, where rank-and-file committees emerged, in some cases with the ability to initiate strikes over the heads of union leaders (Regalia et al., 1978):

> *The diffusion of conflict in the tertiary sector has taken place mainly in imitation of what has happened in industry. This process has not been led by the trade unions to the same degree as in those industries in which unions are weaker, in small enterprises, and in southern factories; but more often it has been a spontaneous attempt by the workers to keep up with what has been obtained in industry, often against the will of the central trade unions. This is especially true for public service employees, whose higher propensity to strike accounts for most of the increased conflict recently shown in the whole of the tertiary sector.* (Regalia et al., 1978: 107)

Union Struggle in Ireland during the 'Decade of Upheaval'

During the 1960s, rapid economic growth boosted the collective confidence of the working class and a high level of industrial conflict prevailed (this was the so-called 'decade of upheaval'; cf. Allen, 1997; McCarthy, 1973). The first signs of an upturn in working-class struggle in Ireland appeared in 1965-66, and a militant campaign for union recognition by a breakaway union in the state telephone company provided a clear indication of the new mood. In October 1965, the Irish Telephonists Association began picketing telephone exchanges to demand recognition. When three strikers were jailed, ITA members picketed the Dáil itself (Allen, 1997). The Taoiseach responded by invoking the Offences Against the State Act, a step which merely galvanised support for the jailed telephonists. The National Busworkers Union pledged its support and Dublin dockers and workers at Gouldings Fertilisers walked off their jobs and marched to the headquarters of the ITGWU, where they abused their leaders for not supporting the strikers. The jailed workers, encouraged by this support, began a hunger strike and 1,500 people marched through Dublin in their support. An agreement was finally reached whereby the hunger strikers were released in return for a commitment not to picket the Dáil.

The Maintenance dispute of 1969 represents the highest point in union militancy in Ireland during the 'decade of upheaval' (McCarthy, 1973). The dispute began with a wage claim by craft workers and escalated after two unions turned down a settlement negotiated by union leaders. Control over the strike fell into the hands of a rank-and-file committee, which organised mass pickets that were so effective that by March, employers were forced to concede the craft workers' full claim – a 20 per cent pay rise – one of the largest granted in industry in this period. The ICTU President denounced the dispute as an example of 'do-it-yourself' unionism "which treats with contempt all the institutions, practices and procedures that our trade union movement has created in this country over the last sixty years" (ICTU Annual Report, 1969: 327; quoted in Allen, 1997: 144).

The fall-out from the Maintenance dispute and the divisions that it created within the union movement convinced both the Government and the union leadership of the need to restore 'orderly bargaining procedures' (Hardiman, 1988: 51). In fact, ICTU entered

into negotiations with the Government and employers in late 1970, leading to the signing of the first National Wage Agreement (NWA). This restored the social partnership model that Fianna Fáil had championed during the early 1960s; the Employer-Labour Conference was revived, meeting monthly to monitor the progress of wage demands, and subcommittees were formed to encourage respect for procedures in the resolution of grievances. The Government subsequently introduced a Trade Union Bill (in 1971) which aimed to shore up the authority of the ICTU leadership by making it more difficult to establish breakaway unions. The ICTU mounted a determined defence of the NWA within the union movement, expelling one union and suspending another over their failure to comply with the terms of the agreement. The Dublin Shop Stewards Committee, which linked together hundreds of rank-and-file representatives, sought to oppose the drift towards centralised bargaining after 1969, but by 1972, rank-and-file militancy had subsided and the union leadership succeeded in regaining control (Allen, 1997).

By 1970, manufacturing industry had become the main source of economic growth and employment in Ireland, and this development was associated with rapid urbanisation. As a consequence, and under pressure from the industrial unions, Congress lobbied the Irish government over union recognition and the expansion of public welfare services. At the same time, the state and employers were growing more receptive to the participation of the labour movement in debates about economic policy:

> *Entry to the European Community and the recession of 1973/74 increased the willingness of government to negotiate pay agreements with unions, while Congress and employers were prepared to do so in recognition of the challenge posed by inflation. Increasingly, it became more difficult to separate the National Wage Agreements from other issues, such as budgetary strategy and welfare provision.* (Girvin, 1994: 128-9)

Neo-Corporatism: Theory and Models

Before discussing the consolidation of concertative bargaining in Ireland and Italy, I will provide a brief assessment of the theoretical approach known as 'neo-corporatism'. This research programme initially sought to explain the apparent convergence of the advanced capitalist countries towards tripartite agreements during the 1970s. Following Olson (1965, 1982), most neo-corporatist writers conceptualise price stability as a 'public good', whose provision depends on the existence of actors large enough to be willing to pay for it and influential enough to be able to enforce it (Crouch, 1985). Only 'encompassing' interest associations fit this description, as their size compels them to deal with the economic consequences of their own wage claims.

Lehmbruch & Schmitter (1982) argue that these peak-level organisations should be considered 'constitutive' of their members' interests; that is, their monopoly position enables them to shape and influence the issues under discussion in a process of 'intermediation' that entails coordinating the competing claims of different constituencies and rendering them compatible. The centralisation and concentration of representative organisations are therefore key variables (Lehmbruch, 1982: 24). Moreover, it is argued that the process of corporatist intermediation is facilitated by long-term transformations in the nature of interest representation in industrial societies, favouring the emergence of monopolistic organisations capable of aggregating the interests of workers and employers and rendering the conflicts inherent in such societies more governable. In line with these observations, Crouch (1978) defines neo-corporatism as the hierarchical, non-conflictual integration of the state and representatives of both capital and labour, arguing that this tends to emerge in situations where capitalism can no longer rely on the market alone to secure the subordination of organised labour.

Niamh Hardiman (1992: 334) underlines the centrality of political exchange to corporatist agreements, a point echoed by Roche (1997):

> *In return for gaining direct influence in the making of public policy, union and employer leaders are expected to co-operate with the state by 'delivering' their constituencies' support for jointly agreed policies, including the pay norms*

> *specified in pay agreements (Panitch, 1980; Goldthorpe, 1984). In a neo-corporatist model of industrial relations the state effectively 'co-opts' the federations or 'peak associations' of unions and employers into the process of governance.* (Roche, 1997: 148)

This gives rise to a 'problem of compliance', as individual members do not necessarily appreciate the imperatives identified by their leaders or the constraints imposed by union incorporation (Streeck, 1982: 32). This problem, which reflects the limits of neo-corporatist intermediation, has led theorists to argue that the leaders of encompassing organisations must be insulated from the disruptive influence of their membership in order to secure the gains offered by concertation. Schmitter incorporates this condition into his definition of neo-corporatism as "a system of interest representation in which the constituent units are organised into a limited number of singular, compulsory, non-competitive, hierarchically ordered and functionally differentiated categories, recognised or licensed (if not created) by the state and granted a deliberate representative monopoly within their respective categories in exchange for observing certain controls on their selection of leaders and articulation of demands and supports" (Schmitter, 1979: 13).

Mainstream theories of neo-corporatism emphasise the gains that this offers to the labour movement, pointing to the generous welfare systems found in 'neo-corporatist' Scandinavian countries and sustaining that even in the context of the economic crisis of the 1970s, neo-corporatist institutions enabled unions to defend many of their earlier gains. Conversely, a militant strategy would have aggravated the crisis and ultimately left workers in a weak situation (Crouch, 1982; Korpi, 1983). Kelly (1988) points out that, despite the high strike rates observed in Britain, Ireland and Italy – the countries with the most unstable neo-corporatist arrangements in Europe between 1950 and 1980 – these countries nevertheless experienced much higher levels of unemployment than those with institutionalised neo-corporatist bargaining arrangements. According to Kelly, this shows that neo-corporatist structures enable unions to defend the interests of the working class as a whole and to achieve a more equitable distribution of incomes. Perhaps for this reason, Bordogna & Provasi (1984) argue that the neo-corporatist model is also appropriate to countries outside North-West Europe.

Before drawing up a balance-sheet for neo-corporatism in Ireland and Italy, it is important to appreciate the differences that exist between different *forms* of concertation and agreement (Teague, 1995: 264). Lehmbruch (1982) suggests that the dominant form of neo-corporatism in Europe during the post-war period involved the participation of strong, 'class-conscious' labour movements in policy formation as a means of defusing social conflict. But the recent experience of concertation in Ireland and Italy is rather different, occurring in a situation of economic crisis and relative weakness of the unions. As I observed in Chapter Two, the process of European Monetary Union (EMU) institutionalised pressures towards deflationary, monetarist and neo-liberal approaches to the labour market and social policy. In objective terms, this has rendered the co-ordination of collective bargaining more difficult than before. Paradoxically, however, EMU has led to a *strengthening* in neo-corporatist arrangements in many peripheral regions of the EU[19], primarily because the dominant union actors in the countries concerned are committed to the agenda of European Monetary Union and are willing to accept wage restraint and retrenchment to this end (Crouch, 2000: 218):

> *And the outcome they seek is mainly negative: avoidance of high unemployment, the right to bargain, and measures of employment security. This logic of the situation and power balance in the new economy explain why the objectives of recent and prospective future revivals of neo-corporatism are not only very limited (e.g. they exclude any attempts at income redistribution), but will usually embody an attempt at reaching neo-liberal goals through the means of corporatist consensus.* (Crouch, 2000: 224)

The goals of low inflation, wage restraint, labour market flexibility and fiscal rectitude have often been pursued in the peripheral countries on the basis of 'social pacts' involving unions and employers. However, these pacts are rooted in crisis, have a tenuous relationship with social democratic political parties and are typically legitimised by reference to the demands of national competitiveness and European

[19] For example, Spain, Portugal, Greece, and Italy experimented with the introduction of centralised agreements for the first time during the 1980s, and this was linked directly to their difficulties in adjusting to EC membership (Hardiman, 1992: 332). Hyman (1994) already anticipated that the process of

convergence. For this reason, Hardiman (2000) suggests that Martin Rhodes' term 'competitive corporatism' (Rhodes, 1998) or Marino Regini's concept of 'organised decentralisation' (Regini, 1999) may be more appropriate than 'neo-corporatism'. Hardiman also draws attention to the contradictory nature of the Irish Partnership agreements, which emphasise 'equity' and 'social welfare' as well as 'competitiveness' and 'flexibility' (2000: 287-88).

Pérez (1999) also argues that attempts in Spain and Italy to adjust to developments in core European countries have had far-reaching effects on the industrial relations system, and Pochet (1998) links this with the periphery of the EMU area more generally, including Portugal, Italy, Spain, Finland and Ireland:

> *These countries, mainly in Southern Europe, face the most difficult adjustments within EMU once the euro emerges from its difficult infancy, with untrusted and inexperienced institutions, and becomes a strong currency. ... Viewing the matter cynically, it is quite possible for national shells of union (and employer) organisations to play an amicable though important game of social reconciliation with each other and with governments, while at factory level a membership with which they have little real contact either behaves as it likes or is so oppressed by high unemployment that it cannot do anything at all, pact or no pact.* (Crouch, 2000: 216)

Critique of Concertation and Neo-Corporatism

During the late 1970s and 1980s, Panitch (1977, 1981) and other radical writers developed a critique of the mainstream theory of 'neo-corporatism', arguing that the latter should be viewed as a ruling-class *strategy* rather than either an ideology or a functional development within 'industrial society'. In contrast to writers such as Schmitter, who suggest that neo-corporatist bargaining enables the labour movement to impose progressive policies on the state, Panitch (1981) argues that neo-corporatist political structures actually provide a vehicle for imposing an intensification of

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European convergence had the potential to generate a consensus around a strategy of centralised political exchange in the periphery of the European Union due to the demands posed by this process.

exploitation on the working class. Its aim is therefore to sustain capitalist accumulation during periods of crisis and economic restructuring.

Referring to the work of Offe and Wiesenthal (1980), Panitch (1981) argues that union power, in contrast to the power of the ruling class, depends on a collective 'willingness to act'. As a consequence, the centralisation of union representation and the incorporation of the unions within neo-corporatist institutions have a much greater impact on the power of the union movement than on that of employers. Moreover, the nature of the capitalist state implies that "only class collaboration, not class struggle, can be practised in the corporatist 'heart' of the state apparatus" (1981: 38):

> *In terms of the effect on trade-union policy of corporatist political structures, the most general is the introduction of capitalist growth criteria within the formulation of union wage policy, the central aspect being the recognition that profit is the condition for future economic growth, including that of wages. ... Thus the maintenance of full employment, the avoidance of inflation, even the rationalisation and concentration of industry, become explicit concerns of unions in formulating wage demands.* (Panitch, 1981: 33)

Panitch's critique of neo-corporatism raises a number of key questions about union strategy, despite the fact that it remains at a rather abstract level. Allen (1999), in contrast, provides a detailed critique of neo-corporatist arrangements in a single country: Ireland. Allen contrasts the increase in wages between 1980 and 1995 (128%) with the more rapid increase in value added per worker (402%), concluding that the period of Partnership agreements saw the share of wages in the national economy fall from 69 per cent (1987) to 59 per cent (1997) (Allen, 1999: 45). Over the course of the Programme for Competitiveness and Work alone, the increase in profits (44%) outstripped wage increases (11%) by a factor of four to one. Not only this, but tax reform during this period resulted in a decline in the top rate of company taxation from 50 per cent (1988) to just 32 per cent; the unions also consented to an extension of the 10 per cent tax rate for manufacturing firms until 2001 (cf. PESP, Section 3.14).

Other Irish researchers have observed that, as the income of the Irish rich increased during the 1990s, the real hourly earnings of the lowest decile of wage-earners stagnated or even declined (Nolan & Hughes, 1997). Callan (2001) shows that the 14 Budgets presented between 1987 and 2001 boosted the income of the richest one-third of families by almost one-fifth, whilst benefiting the poorest one-third by less than 4 per cent. The poorest quintile of families actually lost ground, suffering a decline of 1.2 per cent. Nevertheless, it should be noted that increases in welfare payments almost kept pace with the rise in average earnings during the 1990s. As this contrasts with the British experience, it may plausibly be linked with Partnership[20]. However, Teague (1995) criticises the tendency to equate Partnership in Ireland with the 'social corporatism' found in Denmark and Sweden, arguing that it amounts to little more than union assent to a programme of severe measures to adjust the economy to fiscal crisis and European integration.

In addition to its possible impact on welfare payments, many commentators have emphasised the role of Partnership in creating the conditions for rapid economic growth during the 1990s (Gunnigle et al., 1999; Holohan 1999; McGinley & Filby, 1997 O'Hearn, 1997). Arguably, however, the main determinant of this growth was the increase in foreign direct investment, primarily by American multinational firms in the pharmaceuticals and information technology sectors. Although national wage agreements may have had some influence on the locational decisions of these companies, arguably other factors were more important, including the demographic and educational profile of the Irish workforce and its status as an English-speaking country within the European Union. In this context, it is significant that wage rates in American-owned multinationals tend to be *higher* than in domestic firms, and many of these companies are reluctant to even recognise trade unions (Roche, 1998). Hardiman (1992) draws attention to a final factor that is also of considerable importance:

[20] The PESP states that "[r]ates of social welfare payments have been substantially increased in real terms under the Programme for National Recovery. In the case of long-term benefits, the rate of increase was 27% while all benefits were protected against inflation. A major objective in the context of a new Programme will be to ensure that social welfare recipients are protected and their living standards maintained and, where possible, improved" (Section 4.4).

> *It also seemed evident to the unions that tax incentives were more important than pay levels in attracting direct inward investment. Industrial policy was based on providing attractive corporate tax rates, grants, and a variety of allowances and tax expenditures to attract direct foreign investment and to boost an export orientation. This resulted in relatively heavy employee taxes which implicitly disfavoured employment-intensive investment.* (Hardiman, 1992: 346)

Union Strategies in Ireland and Italy During the Recession, 1977-1987

As I mentioned in Chapter Two, Fianna Fáil initially responded to economic downturn during the 1970s by adopting a Keynesian strategy, but this gave way to a period of retrenchment after 1979. In order to secure the success of this policy the Government sought a long-term arrangement with the unions in order to maintain control over wage increases (Allen, 1997). This agreement went a step further than the earlier National Wage Agreements, and was based on the notion of 'political exchange', paralleling the strategy of the Italian unions and employers' representatives during the late 1970s. The union leaders were to be consulted on a range of issues in return for enforcing pay moderation. Just as the political isolation of the Italian Communist Party in Italy had encouraged the union confederations to adopt a 'reform strategy', ICTU leaders believed that the National Understanding of 1979 would provide them with an unprecedented degree of influence over public policy:

> *The breakthrough we had achieved was historic in that for the first time in this country and indeed in any country and I include the Socialist countries, we now had an acknowledgement that the trade union movement not alone had a voice to be listened to but had to be brought into the circles where decisions are made.* (John Carroll, leader of the ITGWU[21])

But the deflation of the Irish economy after 1979 meant that union action during the first half of the 1980s was mainly defensive in nature, and after employers refused to negotiate a new wage agreement in 1981 there was a return to decentralised bargaining.

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[21] ICTU, Annual Report 1979 (p. 668); quoted in Allen, 1997 (p. 152).

Unlike the aggressive experience of shopfloor strength during the 1960s, however, bargaining at enterprise level during the 1980s brought few rewards for the labour movement. The recession of 1980-81 led to a dramatic growth in unemployment and it is estimated that nearly 200,000 people left the country over the course of the following decade.

In 1982, the Federated Union of Employers called for a more 'hard-headed' approach to bargaining, and there was a decline in the pressure on wages at the point of production. Between 1980 and 1987 unemployment rose from 7.1 per cent to 17.5 per cent, the debt-to-GDP ratio reached 130 per cent and there were genuine fears of national insolvency (O'Donnell & O'Reardon, 1996: 33-38; McGinley & Filby, 1997: 224). Against this backdrop, the Progressive Democrat Party's espousal of neo-liberal policies and pressure from employers for deflation increased union fears regarding the possibility of a 'Thatcherite' shift in government policy (Roche, 1997: 29). Gunnigle et al. (1999) point out that falling membership levels between 1980 and 1987 also pushed union leaders to revise their attitude towards central agreements. Roche (1997) provides a summary of these influences:

> *In 1987 the Irish economy was almost universally seen to have reached its nadir. The public finances had run virtually out of control; the level of unemployment was unprecedented in the State's history; emigration had risen sharply, and union membership had declined dramatically over the preceding seven years. In such a context, market forces began to impinge decisively on free-for-all bargaining, progressively widening pay differentials hitherto fixed by institutional forces. More generally, as discussed earlier, the pluralist model of industrial relations was coming under threat from employers. In addition, the realignment of Irish politics attending the emergence of the PDs held out the prospect of growing support for neoliberal policies and politics. Faced by these circumstances, Irish trade unions thought it advisable to take stock and opt for politics – as much as anything else to find shelter from the storm.* (Roche, 1997: 31)

When the Programme for National Recovery (PNR) was signed in 1987, union leaders believed that it would safeguard welfare services and help to maintain the fabric of

union organisation (Gunnigle et al., 1999: 205)[22]. The PNR restates the Government's intention to reduce the number of public sector employees – in consultation with the ICTU – as well as emphasising the need for wage restraint and control over public spending. It is therefore clear that the PNR corresponds closely to Hardiman's (2000) account of 'competitive corporatism', rather than the classical model described by Lehmbruch & Schmitter (1982). It seems likely that union leaders did not expect the subsequent retrenchment to have been so dramatic. Nevertheless, as talks were entering their final stages, Haughey announced cuts of €622 million in public spending, a step that not only represented a betrayal of Fianna Fáil's election promises (the party used the slogan "Health cuts hurt the old, the poor and the handicapped" during its 1987 campaign) but also constituted a substantial challenge to the nascent 'Partnership' approach.

The idea of focusing spending cuts on the health service may be traced to a policy document prepared by the National Economic and Social Council in 1986, *A Strategy for Development 1986-1990* (NESC, 1986). This publication provided the basis for Fianna Fáil's economic strategy following the 1987 elections:

> *Irish health care expenditure is somewhat above the international average ... at 8.2% of GNP in 1982. ... Figure 1 shows, for instance, than Ireland is an 'outlier' in the scatter diagram relating GNP (per capita) to health expenditure: the share of GNP apportioned to health is very much higher than the share in countries with significantly higher GNP per capita. This may be indicative of some scope for expenditure restraint in the period ahead.* (NESC, 1986: Section 7.2)

In late 1990, as the PNR was nearing its expiry date, the ICTU took the initiative in proposing talks on a new agreement, expressing its willingness to agree on a ten-year development strategy for the country. Like the PNR, the Programme for Economic and Social Progress (PESP) emphasises the importance of achieving a steady reduction in the ratio of national debt to GNP (Section 2.1), arguing that fiscal rectitude will lead to

[22] The introduction to the PNR reads "The Government, the ICTU, the FUE, the CII, the CIF, the IFA, Macra ne Feirme and the ICOS, conscious of the grave state of our economic and social life, have agreed on this Programme to seek to regenerate our economy and improve the social equity of our society through their combined efforts".

an 'employment dividend'. In order to reduce the national debt, the agreement argues that public spending should not increase in real terms until at least 1993, and all signatories indicate their willingness to face up to this challenge "in the longer-term interests of all". The agreement also states that a policy of maintaining interest rates "at the lowest level consistent with international developments" should be adopted (Section 2.4). This three-year agreement provided for pay increases that were slightly below the rate of inflation, and made no provision for above-the-norm payments. The PESP also announced the government's intention to introduce "improvements in the administration and management of the health services in order to ensure the most efficient and effective use of the available resources" (Section 4.52), linking this with the Report of the Commission on Health Funding, the Dublin Hospital Initiative Group and the Hospital Efficiency Review Group (see Chapter Two).

The PESP was followed by the Programme for Competitiveness and Work (PCW) in 1994: "The objective of reducing the debt to GNP ratio, at minimum, to around 95% by 1996 will be pursued primarily through restraint on expenditure. This will require significantly greater restraint on public expenditure than has existed for the past three years, particularly in relation to current expenditure" (Irish Government, 1994: 52). The following agreement was termed Partnership 2000, and extended the scope of the preceding neo-corporatist agreements within the overarching constraints imposed by the Maastricht Criteria and the EU Stability and Growth Pact. Considerable space is dedicated to the 'modernisation' of the public services:

> *In the past thirty years, the importance and influence of the Public Service in Ireland have grown considerably such that its performance in terms of discharging the business of the State has a very significant impact on overall economic efficiency and competitiveness. ... Equally, the process of modernisation must ensure that the Public Service responds better to staff aspirations for more fulfilling work and improved career paths and creates an organisational climate conducive to better job satisfaction, motivation and commitment of staff.* (Irish Government, 1997: 68)

In Italy, it is evident that at the end of the 1970s, the leadership of the Italian union confederations was determined to distance itself from the militancy that had characterised Italian industrial relations during the early to mid-1970s. This change in strategy was influenced by the effects of the recession and by the altered political landscape produced by the decision of the Communist Party to support the Centre-Right coalition government in 1978. This period is referred to as *la svolta dell'EUR* (the EUR turning-point), in reference to the union conference where the three confederations voted to change their strategic approach. In the run-up to this conference, the leader of the CGIL, Luciano Lama, argued that it was absurd to consider wages an 'independent variable' and criticised the excessive rigidity of the unions in relation to redundancies, internal mobility and industrial restructuring:

> *In terms of general union strategies, it is worth recalling briefly the so-called* 'linea dell'Eur' *(beginning of 1978), the most important element of which was, as paragraph 12 of the resolution states, its insistence on the need for a 'real confederal coordination of the bargaining stance' of the sectoral unions, in order to guarantee 'a unifying core to union demands in all areas of bargaining', and finally 'a responsible containment of claims' in preparation for the renewal of collective contracts the following year.* (Bordogna, 1994: 101)

Ironically, the economic downturn made reforms increasingly necessary to the union leadership – the promise of reforms provided the most effective means of convincing the base of the union to accept wage moderation – whilst simultaneously rendering reforms more difficult to obtain. As a consequence, union leaders' ended up embracing a policy stance that was increasingly problematic. In order to pursue their strategy of political exchange more effectively, the leadership of the CGIL embarked upon a centralisation and rationalisation of the organisational structure of the union. This was necessary in order to consolidate the various sections of the union and to integrate them into a structure that was capable of bargaining with employers and the State as well as policing the resulting agreements. This led to union mergers, the closure of militant newspapers such as the train drivers' paper *In Marcia* and, in numerous cases, the collapse of plant-level bargaining.

In the early 1980s, the defensive orientation of the union confederations was evidenced by their consent to cuts in wage indexation (i.e. the *scala mobile*) and their receptiveness to an incomes policy at national level. In 1983, the first tripartite agreement was negotiated, dealing with the *scala mobile*, local wage bargaining and flexibility in recruitment and working hours. The agreement aimed to limit inflation by reducing the protection provided by wage indexation and by freezing localised bargaining; in return the government pledged to reduce the tax burden on workers and to reform elements of the social welfare system. In the same year, a new piece of legislation (law 93/83) rationalised the structure of collective bargaining and introduced the requirement that all public sector wage agreements be 'compatible' with Budget guidelines. The centralisation of bargaining in the public sector was strengthened, although decentralised bargaining over workloads, work organisation and training was still permitted.

The following year, the Craxi Government imposed further cuts in the *scala mobile*, this time without the consent of the CGIL, provoking a split within the union movement. During the negotiations for this agreement, a serious rank-and-file movement emerged within the CGIL, and this was a major factor in the decision of the CGIL leadership to pull out of talks. In February, as details of the negotiations emerged, an assembly of workers at the Iveco factory in Brescia called on all *Consigli di fabbrica* (Factory Councils) in Northern Italy to form a rank-and-file movement to defend the *scala mobile* and to fight for greater democracy within the union (Baccaro, 2000: 586).

Despite the failure of attempts to establish a system of concertative bargaining in Italy during the 1980s, Carrieri et al. (1997) point out that the unions had considerable *informal* influence over the process of state restructuring during the late 1980s, a role that was formalised by the July Accords of 1992 and 1993. A series of pacts were signed in Italy in the late 1980s and early 1990s in an effort to curb inflation and to reduce labour costs, the priority of employers being to reform and eventually abolish the *scala mobile*. For example, the tripartite agreement signed on 10 December 1991 contained short-term anti-inflation measures and committed the unions to maintaining public sector pay increases below the projected inflation rate during the period 1992-1994. The success of tripartite negotiations in 1992-93 was welcomed by many Italian

industrial relations commentators, who viewed this as a necessary step in the consolidation of an 'orderly system of industrial relations' that would boost the competitiveness of Italian capitalism and increase the efficiency of the public services.

The 1992 Accord was facilitated by the decision of the CGIL to adopt a 'new identity' at its 1991 Conference in Rimini, embracing what is commonly referred to as 'new realism'. This led to a restructuring of the union, involving the dissolution of party-based factions and the adoption of a strictly reformist programme based on 'modernisation and moderation' (*European Industrial Relations Review*, November 1991: 16). At the Rimini conference, Bruno Trentin (General Secretary) pointed to the unions' defeat at Fiat in 1980 and during the British miners' strike of 1984-5 as instructive examples of the failure of the 'old model' of unionism. Ottaviano Del Turco, Deputy General Secretary of the CGIL and leader of the Socialist minority within the union, argued that Italy's economic boom during the 1980s had undermined pre-existing class divisions and that the CGIL should become more cooperative, accepting the 'new realities'. This reduced some of the distance separating the CGIL from the CISL and UIL confederations, as the latter were already committed to 'modernisation and moderation' and had demonstrated their commitment to concertation as early as 1984, when the latter two unions had supported Craxi's cuts in the *scala mobile*.

Although there were recurrent tensions between the three confederations during the early 1990s, a more formalised system of tripartite bargaining gradually took shape, and this was facilitated by the overriding concern of the CGIL leadership to avoid exacerbating the existing divisions within the labour movement. The positive attitude of CISL towards the restructuring of the state during the late 1980s and early 1990s is clearly expressed by a resolution passed at its 1996 conference:

> *With the active and indispensable participation of the union, a process of rationalisation and reform that safeguards equity and compatibility has begun in relation to pensions, the health service, social welfare and public services. These reforms are not yet complete and the union is aware of this. However, before studying any new reforms, CISL is determined to respect the time-scale and evaluation procedures that have already been agreed.* (CISL, 1996: 34)

Aldo Baratto, Regional Secretary of the CISL's health service federation (FIST), provided a similar interpretation of the outlook of the union:

> *CISL remains linked to the values of the political Centre, therefore we can say that it represents in some sense a moderate element of society, the part that seeks to provide a social equilibrium, to mediate between the two extremes. This is probably the great strength of the CISL, and it has always sustained that social massification is not desirable because, in a sense, it downgrades the human condition. We believe that society should revolve around the individual, not 'the masses'.*[23]

This has led the CISL to oppose the 'levelling downwards' of wages and to promote the recognition of professional qualifications, social hierarchies and individual capacities. It therefore welcomed the introduction of performance-related pay and incentives within the context of the health service reforms. Similarly, the moderation and 'social catholic' philosophy of the CISL led it to embrace concertative bargaining: "today we have to deal with globalisation, which is no small task. Either you take that as your aim now or you will end up outside the real world, or at least excluded from the European context. Since Italy forms part of Europe, to remove Italy from that context would mean negating Italian culture and would create enormous damage. Concertation is one of the most important themes of European civilisation and of the relationship between the social partners"[24]. Although the CISL does not exclude social conflict as a last resort, it undoubtedly privileges negotiated alternatives.

The crucial shift from an informal structure of concertation to a more stable set of arrangements occurred in 1992, following the formation of the Amato government in June. The ruling coalition included the Socialist Party, the Christian Democrats and the Italian Social Democratic Party, although the Council of Ministers contained five 'technocrats' who were not even party members; this was due to the wave of corruption scandals that had engulfed a large section of the political class. An Accord between the union confederations, employers' representatives and the Italian Government was signed in July in a climate of financial crisis and institutional instability. The agreement

[23] Aldo Baratto, Regional Secretary of FIST Sanità (CISL), Interview U-3.
[24] Aldo Baratto, Interview U-3.

of the 'social partners' was obtained only after Amato threatened to resign, a step that would have plunged the country into an even deeper crisis. The leaders of the unions agreed to a wage freeze until the end of 1993, the elimination of automatic wage indexation, a moratorium on local bargaining and committed themselves to beginning talks on a reform of the collective bargaining system. In return, the government promised a stronger commitment to tackling tax evasion, a token payment of approximately €10 per month to replace the *scala mobile* during 1993 and a concerted strategy to reduce the public deficit. All recruitment to the public services had already been frozen in March as a result of the 1992 Budget. The opening preamble of the Accord is similar to that of Irish Partnership agreements from the same period, making reference to economic crisis, the need to reduce public debt, to meet the Maastricht criteria, to link wage rises with the prevailing inflation rate and to reduce the scope for local pay bargaining[25].

The left-wing faction within the union, led by Fausto Bertinotti (who later became the leader of *Rifondazione Comunista*), condemned Trentin's decision to sign the agreement and called for a ballot of all workers. When the Executive Council of the CGIL met in September, Bertinotti's proposal that workers should be consulted about the July Accord was rejected in favour of a formula that indicated that workers should be merely 'informed' about the deal (*European Industrial Relations Review*, October 1992: 9). At the meeting of the Executive Committee of the CGIL in August, Trentin made the following statement:

> *I was – and still am – convinced that there were 'good reasons' for preferring a signature on a bad deal to a devastating crisis of the union movement that would have made it a scapegoat for the political and financial bankruptcy that still hangs over our public institutions. … Although the economic and financial crisis was caused by other people, it is* our *business, not theirs. And it is our business because*

[25] The July Accord, signed on the 31 July 1992, states that "[t]he social partners take note of the economic policy of the Government and agree with the aim of reducing inflation to 2 per cent by the end of 1994. The social partners recognise the need for businesses to regain competitiveness and adopt the objective of an adequate increase in employment with particular reference to the South. The social partners recognise the determining role of their actions in relation to the implementation of an incomes policy with the central aim of dramatically reducing the rate of inflation". In relation to local bargaining, the Accord states that "[for] all sectors not subject to the self-regulation of the right to strike, all disagreements that emerge at any level and cannot be resolved must be transferred quickly to the next-highest level".

we must be seen to play our part in preventing a worsening of the situation.
(quoted in Nuova Rassegna Sindacale, 14 September 1992, pp. 4-6)

In May 1993, the Italian union leaders entered talks with employers and government ministers on the reform of the collective bargaining system, and a new agreement was signed in July 1993. As in Ireland in 1987, the Italian Government played an active role in promoting agreement between unions and employers, the Prime Minister finally presenting them with a 'take it or leave it' ultimatum after forty days of non-stop negotiations. In common with the Programme for National Recovery in Ireland, the 1993 Accord committed the unions to a policy of wage moderation linked with inflation (the "dynamics of the economic effects of the contract shall be coherent with the planned inflation rate taken as a common goal"[26]), including rigid constraints on local wage bargaining:

The mechanisms foreseen by the Accord involve articulated negotiations based on two annual sessions of incomes policy, one dedicated to the definition of the parameters of economic policy, the other linked with the drawing up of the Budget. Incomes policy is therefore characterised by triangular consultations and assumes the form of a constraint on wage increases, which must fall into line with this.
(Arrigo, 1993: 15)

As a consequence, biennial wage negotiations assume the character of periodic adjustments to bring wage rates in line with inflation, and the provisions relating to decentralised bargaining stipulate that wage increases at local level must be financed by productivity growth and must be different from and not overlapping with the contents of national sectoral agreements. Pay increases agreed at local level are to be "closely linked to the results attained in carrying out commonly agreed plans aimed at increasing productivity, quality and other elements of company-level competitiveness, including marginal productivity, which may be agreed between the parties, in excess of those already used to determine pay increases at the level of the CCNL"[27]. This was one of the most difficult clauses to agree, as the main employers' federation, *Confindustria*, like

[26] Quoted in the *European Industrial Relations Review*, August 1993, p. 16.
[27] Quoted in the *European Industrial Relations Review*, August 1993, p. 16.

the Irish employers in 1987, was unwilling to concede company bargaining and only accepted the agreement on the basis of an extremely restrictive form of local wage negotiations.

Anticipating internal dissent, the leadership of the CGIL proceeded to consult members on the deal, and between July 3 and July 23 30,000 workplace assemblies were held. These meetings were carefully orchestrated, officials informing workers that the Accord represented a victory for the labour movement, that it would promote employment growth, an equitable distribution of incomes and facilitate the renewal of factory councils. Only union officials who were in favour of the agreement were allowed to speak (*Il Sole 24 Ore*, 23/7/1993) and practically no information on the contents of the agreement itself was circulated before the assemblies. Although 68 per cent of those who participated voted in favour of the agreement, only a small proportion of the membership participated, even in sites where assemblies were held. It is therefore difficult to agree with Baccaro (2000), who argues that the referendum, for a change, enabled the 'silent majority' within the CGIL to direct its policy stance.

Thus, the 1987 Programme for National Recovery in Ireland and the Italian Accords have a number of similarities, which may be linked with the pressures created by the process of European Monetary Union within peripheral regions of the EU. This provides further evidence for the pertinence of the typological distinctions outlined in Chapter One between 'particularistic' welfare states and other welfare regimes in Europe.

Due to the structural weakness of the unions and the concerns of the state to meet the convergence criteria established by the Maastricht Treaty, the government and union leaders were much more enthusiastic about national agreements than employers. In fact, employers' representatives only accepted these agreements on the basis that the negotiated wage increases were in line with, or slightly below, predicted inflation rates. This is accord with Panitch's insistence that neo-corporatist arrangements entail the incorporation and demobilisation of labour movements and engineer their support for a class offensive geared towards increasing profits, although it is clearly important to contextualise this process. It is therefore difficult to view the National Agreements in

Ireland and the Italian Accords as a step towards a Scandinavian model of social partnership in which a strong union movement uses the framework of neo-corporatist bargaining to impose social reforms upon the state and employers.

The only satisfactory explanation for 'competitive corporatism' in the European periphery takes as its starting point the specificities inherent in the political culture and economic position of these countries. Although the content of the aforementioned agreements is avowedly neo-liberal and unashamedly supportive of capitalist accumulation, the fact that they facilitate participation in European Monetary Union and provide a role for the union movement in the policy-making process was sufficient to ensure the support of union leaders. One of the justifications that the union leadership offered for its decision to participate in national agreements is the opportunity that this provides for influencing welfare policy. It is therefore important to ask whether the unions were able to influence the programme of health service rationalisation and how they responded to this process.

Responses to Health Service Rationalisation in Ireland

In August 1987, the Alliance of Health Services Unions in Ireland – an ad hoc grouping of unions with members in the health service – requested a meeting with the Department of Health in order to express their concern at the acceleration in hospital cuts and their impact on the health services (*Industrial Relations News*, 27/8/1987, p. 7). However, despite promises that the Alliance would be consulted prior to the implementation of service reductions, within a few days a major Dublin hospital had unilaterally announced a reduction in the number of hospital beds from 500 to 135 as well as severely curtailing accident and emergency services (*Industrial Relations News*, 3/9/1987, p. 7). Although this pattern was repeated throughout the health service, the Alliance did not call industrial action in protest at the cuts, and concentrated primarily on securing advantageous terms for the voluntary redundancies sought by the Government.

Thus, the response of the health unions to health service rationalisation in 1987 was primarily vocal and focused on cuts in services rather than the pay and conditions of health workers. Nevertheless, health workers participated alongside teachers and public servants in protest marches against the cuts (McGinley & Filby, 1997: 214) and a motion of censure was passed at the INO conference in October in protest at the reduction in community healthcare and geriatric services. However, the Minister for Health promised conference delegates that there would be 'no further bombshells' (i.e. no more dramatic cuts in the health service), and this seems to have satisfied the union.

Similarly, when the Taoiseach (Prime Minister) and Minister for Health addressed the annual conference of the Local Government and Public Service Union (LGPSU) in October 1987 – the first occasion on which a Taoiseach had addressed a major union conference – sharp criticism of the cuts was voiced, but again this did not go beyond words. The fact that severe cuts in health funding did not jeopardise the nascent Partnership system testifies to the determination of the ICTU to reach an agreement and signals its implicit acceptance of the Government's 'shock therapy'. Essentially, the Irish Congress of Trade Unions agreed to cuts in the health service on the basis that redundancies would remain voluntary. At the same time, ICTU sought to defend wage levels and to secure assurances that privatisation would be confined to the Irish Life.

The negotiation of the PNR was followed by a series of mergers within the Irish union movement that reduced the number of unions. In the process, the possibilities for democratic participation were reduced as union conferences became more infrequent and leaders occupied unelected positions for longer than before (Allen, 1997). As a result of this process, unions such as SIPTU, IMPACT and the ATGWU were able to dominate negotiations due to their influence within ICTU. Indeed, SIPTU accounts for two-fifths of all union members covered by Congress (1994 figures). Thus, as in Italy in the late 1970s, the drive towards 'political exchange' at national level led to a more centralised, less democratic form of union organisation that enhanced the role of the union leadership.

As I noted earlier, there are a number of similarities between Irish and Italian industrial relations during the 1970s (Crouch, 1992: 174; cf. Regini, 1982), although the level of industrial militancy in Ireland was lower than that observed in Italy. In both countries, rank-and-file militancy encouraged union leaders to pursue a strategy of political exchange. As a result of the pressure of shop-floor militancy during the 1970s and of centralised bargaining during the 1980s, industry-wide collective bargaining assumed less importance in these two countries than in many other European countries (Regini, 1992).

The strength of the Irish and Italian labour movements also provided the Government with an incentive for including union officials in policy discussions during the late 1970s. The level of industrial struggle remained high in Ireland throughout the 1970s, with an average of 665 working days lost per 1,000 employees between 1971 and 1980. This was considerably lower than the figure for Italy (1,461) but nevertheless much higher than in Germany (53) or the Netherlands (36) (Crouch, 1992). Gunnigle et al. (1999) note that the number of working days lost due to strikes during the 1970s marked a 30 per cent increase on the previous decade, with unofficial action accounting for more than two thirds of all strikes (p. 202). Crouch (1992) links this with aspects of the political economy of these countries:

> *Finland, Britain, Ireland and Italy were countries in which the new shop-floor pressures were particularly strong, but whose institutions were clearly trying to venture down a similar road to the more clearly neo-corporatist cases. In each nation there were steps towards greatly increased national involvement by central union leaderships, probably more intensively in Finland but prominent in all these cases. The institutions did not yet have the intricate complexity of constantly growing scope for exchanges typical of the established neo-corporatist systems, but behaviour was reminiscent of the early stages of these...* (Crouch, 1992: 172-3)

These similarities may be linked with the industrial composition of these countries, both of which are characterised by a sharply polarised productive system in which a small number of large firms account for a substantial share of manufacturing output, alongside a large pool of small firms and a disproportionately large public sector[28].

The Emergence of the Rank-and-File Unions in Italy

The responses of the Irish and Italian union movements to the downturn in industrial militancy during the 1980s – whilst adopting different forms – also generated rather similar tensions within the unions. The most striking expression of tensions within the Italian union movement during the 1980s was the emergence of new union actors capable of leading militant industrial action, particularly in the public sector. Action by teachers and transport workers between 1986 and 1988 epitomised this new form of militancy, although the model of the Cobas (*Comitati di base*) subsequently spread to other areas of the public sector and even appeared in manufacturing industry in the early 1990s.

I will provide a brief summary of the struggles of Italian teachers during this period, as this occupational group has a number of similarities with nurses. As a result of industrialisation and the expansion of the education system, a new generation of teachers entered the Italian schools during the 1960s. During this decade, many teachers transferred their allegiance from moderate 'autonomous' unions to the union confederations (CGIL in particular) and a rapid decline in the 'Catholic ethos' of teaching occurred. As teachers were radicalised by changes within their profession and by the upsurge in strike activity across the workforce, the contradictions within the school system became increasingly evident.

[28] For example, large multinational firms accounted for two-thirds of Irish manufacturing output and 40 per cent of employment in the late 1990s (Roche, 1998). In Italy, the six leading conglomerates accounted for 80% of Italian companies' foreign acquisitions in 1990 and in 12 of the 27 leading sectors, the four largest enterprises accounted for over 45% of total sectoral turnover (*European Industrial Relations Review*, July 1991). In 1990, public sector employees accounted for 17.4% of total employment in Italy and 17.9% in Ireland, compared to 15.6% in the OECD.

During the post-war period, low pay in teaching had been counterbalanced by a relatively short working week, an autonomous work process, relatively high social status and job security. By the 1970s, however, teachers were faced with larger class sizes, a larger burden of preparation, tighter control by head-teachers and uncertainty about changes within the system itself. Santi (1989) reports that incomes grew more slowly in the public sector between 1970 and 1984 than in the private sector, and Carrieri and Tatarelli (1997) observe that the real incomes of public employees declined between 1981 and 1986[29].

It is perhaps unsurprising, therefore, that up to 90 per cent of teachers adhered to the strike called by the union confederations in November 1986 to demand a new contract. This one-day strike triggered a process of radicalisation which quickly marginalised the leadership of the CGIL, CISL and UIL unions. By bringing together teachers who were previously uninvolved in union activities, the strike created a momentum for change. Thus, the teachers' struggles of the late 1980s followed the 'pressure cooker' model almost exactly: the accumulation of grievances in a poorly-organised category creating an explosive situation. As I will show in Chapter Six, this model of industrial relations is of crucial importance as far as nursing is concerned, and the Irish nurses' pay campaign of 1996-1999 constitutes a textbook example.

Although union leaders provided the spark that ignited militancy amongst Italian teachers during the 1980s, they were very quickly left behind by the pace of developments. The Cobas emerged in a relatively spontaneous fashion in the days immediately following the 1986 strike, channelling teachers' dissatisfaction with the track record of CGIL, CISL, UIL and SNALS. During the period of mobilisation that followed, the Cobas called a series of strikes and, most controversially, an exam boycott. By Summer 1988, the union confederations were under severe pressure, and attempted to 'outflank' the Cobas by adopting a tougher bargaining stance.

[29] According to research by IRES, the research wing of the CGIL, public sector pay increases outstripped private sector pay during the second half of the 1980s. Public sector pay grew by 15.2% in real terms between 1985 and 1989, in contrast to just 7.8% in the private sector. The average increase in public sector pay was 9 per cent in 1990 (*European Industrial Relations Review*, August 1990).

The phenomenon of the Cobas is interesting because it attempts to transfer an organisational form and a set of militant union practices from one context to a rather different one: from radical workers during the 'hot autumn' to an occupational group in the public sector with a weak tradition of union participation and a rather 'middle-class' complexion. Mainstream Italian industrial relations commentators present a highly negative picture of the Cobas, however, with Baldissera (1988, 1990), for example, describing this movement as 'middle class', arguing that it exploits collective action in order to implement a strategy of exclusion in relation to manual workers and to reinstate earnings differentials that were compressed by the egalitarianism of the 'hot autumn'. He equates militant teachers in 1986-88 with the 'march of the 40,000' in Turin, when supervisors took to the streets to demand an end to an extended strike by metal workers' in 1980.

It is interesting to compare the rapid expansion of the non-confederal unions in Italy during the 1980s with the growth in white-collar unionism in the Anglo-Saxon countries during this period. For example, one of the unions that recorded the most rapid rate of membership growth in Britain during the 1980s and 1990s was the Royal College of Nursing, which, like a number of other white-collar unions, grew increasingly militant during this period. Similarly, the Irish Nurses Organisation (INO) increased its membership from 12,900 in August 1989 to roughly 16,000 in August 1995 (an increase of roughly 25 per cent in six years), reaching 17,000 by the beginning of 1997[30]. This growth in membership took place against the backdrop of localised work stoppages and work-to-rules against inadequate staffing levels, long and anti-social hours, unsafe practices and lack of autonomy. Public sector discontent also exploded in other European countries during the late 1980s, including France (Winter 1986-7 and during 1988), Spain (Spring 1987) and Britain (1989). Ferner (1991), discussing the strike wave in France in 1988, observed that the movement that took shape in response to the

[30] The Irish Nurses Union was established in February 1919 and affiliated to the Irish Women's Workers Union. In 1928, when the INO left the IWWU in order to develop a more exclusive focus, total membership was 437 (Power, 1996: 25). The INO grew during the 1930s and 1940s and obtained legal recognition in 1949 by registering as a company, after which time it engaged in collective bargaining on behalf of general nurses. A more aggressive approach was taken to recruitment and branch organisation during the 1960s, combined with an active public campaign to highlight the inadequacy of nursing pay, and membership reached 5,070 by the mid-1960s. A major pay battle in 1970, public protests and industrial action raised the INO's profile further and the union affiliated to the ICTU in January 1990.

government's hard-line policy quickly grew into a protest against the union leadership and its failure to express the frustrations of rank-and-file union members.

Responses to Health Service Rationalisation in Italy

Although the leaders of the CGIL, CISL and UIL unions accepted the July Accord in 1992, there was an immediate, rank-and-file revolt. Spontaneous committees were created by union activists from the more militant *Consigli di fabbrica* in the metal-working industry, who linked together to create a movement of *autoconvocati* ('self-convened' rank-and-file committees). The anger of union members was fuelled by the severity of the cuts announced in September and by the devaluation of the *lira*. In the Autumn, 230 *Consigli di fabbrica autoconvocati* organised protests across the North of Italy. The *European Industrial Relations Review* (November 1992) reported in succinct fashion that "union members grow ever more distrustful of their leaders and increasing numbers are returning their membership cards" (p. 9). The mobilisation of the *Consigli* forced the leadership of the confederations to support a series of demonstrations in early October – the largest in more than ten years. Union leaders received an extremely hostile reception on these marches and were forced to leave platforms throughout the country under a hail of potatoes, bolts and catcalls; in Florence, the General Secretary of the CGIL, Bruno Trentin, was physically assaulted by a male nurse despite a 400-strong *servizio d'ordine*. Carrieri (1997) describes this as "a period when the hurling of bolts and street-fighting returned to union demonstrations".

The protest movement continued throughout Autumn 1992, and in late October achieved a considerable victory when the Prime Minister withdrew the income threshold for health care imposed by the Budget. Thus, under the pressure of the union membership, the response of the Italian unions to health service rationalisation was more mixed than that of the Irish unions, as a rank-and-file revolt during 1992 forced the leadership to call action against the introduction of service charges for health care leading to a partial reprieve. The resilience and combativity demonstrated by union activists, particularly within the CGIL, recall the rank-and-file revolt against the *Accordo di San Valentino* in 1984 and highlight the considerable differences in outlook that characterise various elements of the Italian labour movement. These traditions, the

organisational form of the *autoconvocati* (rank-and-file movement) within the CGIL as well as the active role of the rank-and-file unions (including the *Cobas*) ensured that Italian union officials encountered greater difficulties than their Irish counterparts in developing neo-corporatist bargaining structures at national level.

It was against the backdrop of the revolt of the *autoconvocati* and the protests by rank-and-file unions in 1992 that parliamentary debates about the restructuring of the Italian national health took place, leading to the ratification of a major health 'reform' in December 1992 (see Chapter Two). But in contrast to the union leaders' opposition to health charges in the late 1980s and early 1990s, the changes introduced in late 1992 in the financing and organisation of the health service met with broad approval. In fact, as early as March 1992, during debates about the reorganisation of the health service, Alessandro Ruggini, the National Secretary of the Public Sector branch of the CGIL made the following statement:

> *The problems of [health service] management necessitate radical choices in the form of a policy of reforms that provide for the devolution of powers and a stronger regional decentralisation alongside a process of* aziendalizzazione. *Regionalisation and* aziendalizzazione *represent, together with the transparency of responsibilities and a new flexibility at local level, the only responses that can satisfy the new health demands made by citizens.* (quoted in Nuova Rassegna Sindacale, 30/3/1992, p. 33)[31]

A similar position was adopted by Pino Schettino, from the same organisation, who stated rather cautiously that "we are in agreement with the *aziendalizzazione* of the LHUs, but not in the form that the legislation foresees. Similarly, we are in agreement with the rationalisation of the hospital system, as long as this does not translate into indiscriminate cuts in bed numbers" (quoted in *Nuova Rassegna Sindacale*, 14/9/1992, p. 16). Giuliano Cazzola from the Social Policy Department of the CGIL, sustained that "[t]he welfare state has not come crashing down around us and we have not only

[31] As I explained in Chapter Two, the term *aziendalizzazione* (which cannot easily be translated into English) refers to the transformation of public bodies into 'enterprises' that resemble private companies in terms of their management structure and approach and their use of modern techniques of cost accounting and strategic planning.

experienced defeats in recent months ... As far as the health service is concerned, notwithstanding last-minute surprises in the legislation, a phase of fundamental restructuring of the system is about to start. All of this should not be forgotten when we express a negative verdict in relation to access and service charges..." (*Nuova Rassegna Sindacale*, 7/12/1992, p. 21). Although Cazzola's position was subsequently challenged by Ivan Cavicchi, Coordinator of the CGIL's health division (see *Nuova Rassegna Sindacale*, 28/12/1992 and 15/2/1993), the critics remained a small minority.

When discussing the responses of the Italian confederations to health service rationalisation in 1992, it is important to remember that these unions had been calling for the rationalisation of public services since the late 1970s and early 1980s. Since the *svolta dell'EUR*, in fact, official union policy had emphasised the need to increase the efficiency of the public services in order to pursue a 'new development model' (Lange et al., 1982: 172). The unions criticised the clientelism and inefficiency that permeated the Italian public sector and argued that this prevented Italian capitalism from becoming a high-wage, high-productivity economy.

This analysis was shared by the Communist Party, which opposed the nationalisation of private companies during the 1970s on the grounds that this obstructed industrial restructuring. CISL and UIL had their own reasons for accepting health service rationalisation in 1992, as the political parties with which they were most closely linked formed part of the Amato government. Amato, a Socialist Party member, represents the social-catholic political tradition in Italy, which is the dominant influence on CISL policy, as I noted earlier. This tradition looks to the voluntary sector as a means of overcoming the 'massification' of welfare provision, controlling public spending and enhancing the role of lay organisations in the delivery of services. For example, one of the resolutions passed at the national conference of the CISL in 1996 states that welfare services should be "guaranteed and in part financed by the State, even if mediated and managed by associations, communities, churches and social centres" (CISL, 1996: 33).

When the Executive Committee of the CGIL met in early 1993 to discuss the proposed amendments to the 1992 health reforms, the only specific criticism that was made was in relation to the lack of emphasis on health promotion. When the Committee met again

in July 1993, criticism was confined to the Government's decision to reduce the degree of regional decentralisation and *aziendalizzazione*. Thus, the CGIL supported a radical reform of the health service founded on decentralisation, managerialism and the reduction of service coverage during the early 1990s. Nevertheless, all three unions opposed the proposal to create a subsidised private insurance scheme (*Nuova Rassegna Sindacale*, 2/8/1993). The support of the union confederations for health reform is also evident from one of the joint statements they issued in 1993:

> *The fundamental aims of the union confederations in relation to the Government are development and equity. In order to pursue these objectives, CGIL, CISL and UIL have contributed to the improvement of the public accounts by participating in incomes policy and have become important actors in the restructuring of the pension system and the health service by means of radical reforms that have led to profound innovations in these fundamental areas of welfare provision, increasing the efficiency of social spending. ... Italian welfare spending should therefore be considered an investment that enhances the potential for development, increasing the productivity of the country and boosting its competitiveness in international markets.* (quoted in RdB, 1997: 81)

Alongside the union confederations, there are two other important groups in Italy. These are the professional/category-based unions, on the one hand, and the 'traditional' autonomous unions, on the other. Like the Irish INO and PNA, professional unions such as the FAPAS restrict their membership to specific occupational categories[32]. These unions, unlike the rank-and-file organisations, explicitly adopt a restricted form of representation and are characterised by pragmatism, an apolitical outlook, a lack of ideology and a less antagonistic relationship with the CGIL, CISL and UIL unions. In contrast to the INO (but in common with the PNA) in Ireland, they emphasise the effectiveness, sensitivity and 'rootedness' of local union structures (Carrieri, 1997: 34). With a high level of participation at workplace level – albeit without the exclusive emphasis on assemblies and participatory democracy found amongst the rank-and-file unions – the professional and category-based unions are also capable of undertaking militant industrial action in defence of their members' interests.

The traditional 'autonomous' unions have a long history in Italy, and are linked primarily with right-wing political parties such as the fascist MSI (which evolved into *Alleanza Nazionale* at the beginning of the 1990s). These parties – and unions – were marginalised as a result of the development of a party-ancillary union movement during the 1950s. The CISNAL union (which was refounded in the mid-1990s as the UGL, following the emergence of *Alleanza Nazionale*) was formed in 1950 by members of the MSI, and drew inspiration from the experience of revolutionary syndicalism at the beginning of the century as well as from Italian Fascism. CISAL was formed in 1957, drawing members from CISNAL as well as from other unions in the semi-state sector, local authorities and in the public administration[33]. CONFAIL emerged in 1964 as a result of a split within the CISAL union, and a number of other unions with less explicit political affinities developed in the public administration during the 1950s and 1960s, often with a limited geographical or occupational profile (such as CONFSAL, FIALS and CISAS in the health service).

These unions are typically described as 'sectionalist' by representatives from other unions, as the following extract from an interview with a regional CISL official indicates:

> *The autonomous unions emerged as an expression of vested interests … in order to represent certain occupations or factions. They do not represent common interests, they only represent these interest groups, and therefore they have absolutely no legitimacy as far as we are concerned.*[34]

Within the health service, the autonomous unions typically adopt a strategy of alliances in order to strengthen their bargaining position. With a relatively low level of membership participation, they tend to rely on sponsorship by management in order to sustain membership levels, at times embracing the clientelistic logic inherent in the Italian public service. Nevertheless, in some areas of the public sector, unions such as

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[32] Other examples include the *Gilde* in the schools, the flight attendants' ANPAV and the various doctors' and pilots' unions.
[33] CISAL currently claims just under 2,000 members in the health services in Campania.
[34] Aldo Baratto, Interview U-3.

FAILEL-CONFAIL (FAILEL is the federation of public service unions within the CONFAIL confederation) have campaigned against managerial corruption and clientelism[35]. For example, Giuseppe Cangiamila, National Secretary of FAILEL-CONFAIL, has exposed irregularities in the management of the health service in Naples, such as the assignment of individuals who were hired as nurses to other roles within the hospital, by writing letters of protest, denouncing illegalities to the authorities and by sending press releases to local newspapers[36]. The main attraction of these unions, for disillusioned members of CISL and UIL in particular, is their autonomy from the union confederations, their moderate stance and their rhetoric of 'modernisation' and 'reform'.

The response of the traditional autonomous unions to the health service 'reforms' of the early 1990s, like that of the union confederations, was generally favourable. The proposed organisational changes, financial rigour and managerialism coincided with their 'moderate' outlook and support for 'modernisation'. For example, Enzo Mazzola, National Secretary of FLS-CISAL (the health services wing of the CISAL union), provided the following statement of his union's position on *aziendalizzazione*:

> *[Researcher: Are you in agreement with the process of* aziendalizzazione*?]* Aziendalizzazione *represents an objective that has not yet been fully defined: that of the privatisation of the health service. This will lead to positive results, we hope.*[37]

As with the historic union confederations, the world of rank-and-file unionism is extremely heterogeneous, and it is therefore necessary to explain the differences between the organisations before assessing their attitude towards health service rationalisation. These differences are primarily political in nature, but they are also linked with the organisational structure of the different rank-and-file unions and their relationship with the *sinistra sindacale* (left-wing opposition) within the CGIL. The first model is that of the Cobas, and is characterised by a 'movementist' approach based on dual membership and a rejection of 'bureaucratic' forms of organisation. This model is

[35] FAILEL-CONFAIL claims to have 9,000 members in the Italian health service.
[36] Interview by the author, 5 September 1997.

largely confined to the school system, and it is therefore misleading to use the label 'Cobas' to refer to all forms of rank-and-file unionism. The second model is that of the CUB/RdB, which seeks to reconstruct the *sindacalismo di classe* of the hot autumn on the basis of an *exclusive* identification with a rank-and-file union. As I stated earlier, the notion of *sindacalismo di classe* implies a comprehensive rather than an exclusive political identity, but one that is centred on the interests of the working class:

> *Our members can come from any political background whatsoever, but when they join the union, they have to know that we have… that they have joined a union that has a precise political project, namely to present itself as a political/union actor that opposes the concertation of the confederal and autonomous unions, the Government,* Confindustria, *the notion of 'compatibility' (i.e. with economic criteria), that is against the policy of 'sacrifices'. THIS is our… A union that is based on the principle of democracy that we had with the factory councils and on the principle of the assembly.*[38]

The CUB describes itself as a 'non-ideological, non-sectional mass union confederation, with full autonomy from the parties, the state and the bosses' (quoted in Carrieri & Tatarelli, 1997: 105). It emerged in 1992, when a heterogeneous grouping of rank-and-file groups – many of which were linked during the 1970s with *Avanguardia operaia* – merged to form a confederation that brought together workers in industry and the public services. The use of the acronym CUB (*Comitati unitari di base*) is itself significant, as it recalls the political committees that played a key role in sustaining the struggles of the Italian working class during the hot autumn. Many of the CUB in 1968-1969 were led by members of revolutionary groups such as *Potere operaio*, *Avanguardia operaia* or *Lotta continua*, and the most influential were able to call strike action autonomously.

Rather than mobilising members of the existing confederations within a loosely-structured rank-and-file movement (along the lines of the Cobas), the CUB seeks to construct an enduring pole of attraction in order to challenge CGIL, CISL and UIL at all

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[37] Enzo Mazzola, National Secretary of FLS-CISAL, Interview U-5.
[38] Gaetano Marati, leader of the RdB in Naples and member of the National Executive Council of the RdB, Interview U-6.

levels of union representation[39]. The CUB is also critical of the school-teachers' Cobas, and one of the leaders, Piergiorgio Tiboni, comments that "we are separated from the Cobas in the schools by a different conception of union action. They are overly 'movementist', whereas we believe that the workers need a rank-and-file *union*" (quoted in Carrieri, 1997: 106).

The third model of rank-and-file unionism found in Italy is that of the 'red union', or *sindacato-partito*, which espouses not only an independent and class-based form of union organisation, but combines this with a far-left political platform informed by the experience of the revolutionary groups during the late 1960s and early 1970s. The best example of this model of unionism is SLAI-COBAS, which seeks to bridge the gulf that has tended to separate rank-and-file unionism in the public sector from workers in the large metalworking factories[40]. Its main success to date has been in elections to workplace representative bodies at the car-making plants in Pomigliano d'Arco and in Arese, where it has been able to challenge the dominance of the CGIL.

The development of rank-and-file unionism in Italy should be situated within the context of developments in the political arena. In particular, the transformation of the Italian Communist Party between 1989 and 1991 generated two new political parties, one of which evolved into a moderate social-democratic party of government (the *Partito Democratico di Sinistra*, later renamed *Democratici di Sinistra*), the other of which comprises a contradictory mixture of Stalinism, Third-Worldism and workerism (the *Partito della Rifondazione Comunista*). As the governmental aspirations of the *Democratici di Sinistra* crystallised during the 1990s, the PRC effectively aligned itself with the rank-and-file unions and the left-wing opposition within the CGIL (the so-called *sinistra sindacale*).

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[39] For example, the first national conference of the metalworkers' section of the CUB in 1995 argued that "[i]t's dangerous to continue to have illusions in the possibility that workers can condition the choices of these bureaucrats" (quoted in Carrieri, 1997: 107).

[40] The SLAI was formed in the early 1990s, when a number of rank-and-file groups based in manufacturing plants in Lombardy created first the Coordinamento dei Cobas dell'industria, and subsequently the Sindacato lavoratori autorganizzati (SLA) (merging with 'self-organised' groups from Fiat and Alfa Romeo). When the union began to expand outside manufacturing industry, an 'I' (for intercategoriali) was added to its acronym. The SLAI came together with workers from various areas of the public sector in 1992 to form the SLAI-COBAS, which Carrieri (1997) describes as a 'non-union' or 'anti-union' due to its far-left anti-capitalist political stance and commitment to a vanguardist approach to union struggle.

The position of the rank-and-file unions in relation to health service rationalisation stands in marked contrast to that of the other union actors, and the RdB, for example, criticises the new industrial relations regulations as well as the rationalisation of the welfare state. Gaetano Marati, member of the National Council of the RdB, summarises this position as follows: "...we have a general position in relation to the process of privatisation, in relation to the (law) 502, the (law) 29, that is very precise: we are against this process and we have been fighting against it since the period of De Lorenzo"[41]. The ultimate aim of the union is to construct a truly public national health service:

> *We are in favour of public management of the health service, in the sense that it is a primary and essential service foreseen by the Constitution. [Researcher: And how do you respond to those who say 'but look what happened to the health service after 1978: the corruption, the inefficiency?] We want public health care precisely for that reason, because we are convinced that what happened was due primarily to the fact that the public health service was not really public.*[42]

Responses to Health Service Rationalisation in Ireland: The Nurses' Pay Campaign, 1996-1999

The nurses' pay campaign between 1996 and 1999 undoubtedly represents the most important 'response' to health service rationalisation in Ireland. Although the leadership of the largest general unions in Ireland generally cooperated with the spending constraints and organisational changes implemented from 1987 onwards, the nursing unions grew increasingly critical of rationalisation during the early 1990s. As a result of falling staffing levels and overcrowding, nurses were involved in localised industrial action over working conditions during the 1990s in a number of hospitals. This experience prepared the ground for the pay campaign. Moreover, in October 1993 the INO voted to oppose negotiation of a successor to the Programme for Economic and

[41] Interview U-6.
[42] Gaetano Marati, Interview U-6.

Social Progress. Thus, it is apparent that the 'docility' of the INO was being eroded[43]: "The INO's approach down through the years reflected the sort of approach of nurses – too high a degree of docility, too high a degree of compliance and not enough assertiveness, and on occasion aggressiveness"[44].

The pay campaign began in late 1995 when talks between nursing union officials and health employers in relation to a union claim for a pay increase worth roughly 10 per cent, presented under the terms of the PCW, broke down[45]. The nursing unions balloted their members on the deal, and the offer was rejected, despite the best efforts of the union leadership to 'sell' the deal[46].

After the pay offer had been rejected, the leadership of the four nursing unions – INO, SIPTU, PNA and IMPACT – called a series of regional assemblies, and these revealed the extent to which the traditional deference of nurses had evaporated. The union leaders were literally astounded by the militancy of their members, who expressed their outrage at the Government's offer and their anger at their leaders for having recommended acceptance of the offer. Des Kavanagh, General Secretary of the Psychiatric Nurses Association, described what happened at one meeting: "We held a final night, I think it was over in Juries, and we were thinking "someone'll be killed here"! And the American Embassy was ringing up to say there were cars parked everywhere, and they were horrified at what was going on. And I think we could have filled Croke Park (the football stadium), we certainly could have made a big impact on Croke Park had we got it!"[47]

Liam Doran, Deputy General Secretary of the INO, describes the evolution of the pay campaign and the response of nurses to the initial ballot:

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[43] The INO was historically viewed as a 'yellow' union or 'Matron's union' by other unionists, who even referred to INO representatives as the 'blue rinse brigade'.
[44] Interview U-11. At the time of the interview, Liam Doran was Deputy General Secretary of the INO.
[45] Clause 2 (iii) A and 2 (iii) B of the PCW provided for an additional increase of up to 3 per cent on the basis of "changes in structures, work practices or other conditions of service" that result in savings, increased efficiency and an improved quality of service.
[46] INO sources indicated to the author that the then General Secretary refused to discuss this with other senior officials, and insisted that they 'go out and sell the deal'.
[47] Interview U-13.

There were policy documents: 92 (the conference) adopted a clear statement, I remember that quite explicitly, they adopted a clear statement of "we are going to target the money at LSI's" (long service increments). ... So that was fine, we commenced our negotiations, we submitted a statement of case, running to – I'm not being smart, but I wrote every word of it – running to 93 pages which clearly tabulated exactly what we want for each grade. ... We came out, first thing we were told by the same members was... the catch cry became "there is nothing in it for the one to eights. Now what the catch cry was for was that for the first 8 points on the incremental scale there was nothing in it, and that is a fact. But then we were told to target the increases at the max. of scale, which is the 9th point. What happened then would be an interesting exercise from your point of view, is that this organisation secured a significant increase in its membership, but that increase in its membership was a completely different breed of member, with a different age profile, a different outlook on life and a much more assertive stroke aggressive outlook on getting what it wanted.[48]

On this basis, the unions rejected a further offer drawn up by a special adjudication body and balloted on industrial action in support of their demands. The unions were seeking large increases at the top of the nursing pay scale, the abolition of lower entry grades, full incremental progression for temporary staff, the creation of a dual pay scale for nurses with midwifery and sick children qualifications and early retirement at 55 years. Industrial action was averted at the eleventh hour when the Labour Court invited both sides to talks at the beginning of February 1997. The Court subsequently recommended pay increases of between 6.5 per cent and 11.6 per cent, depending on grade, and an 18 per cent rise at the top of the pay scale. Lower entry grades were to be abolished and early retirement was introduced at 55 on the basis of 35 years' service. The Court also established a Nursing Commission to study other aspects of the professionalisation of nursing and recent developments in nursing work. The unions called off the threatened strike and balloted their members on the proposal. The final deal, worth approximately 17 per cent in terms of the nursing wage bill, was accepted by a majority of members. This clearly represented a major victory for nurses, although many continued to believe that more could have been achieved:

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[48] Liam Doran, Interview U-11.

They should have went ahead with it that time. Because I think that was the first time in years that I think nurses have been taken seriously. I think everybody believed that they were going to strike and then at the last minute... [Researcher: Would it have been a positive thing if they'd gone ahead with it?] Yeah (no hesitation). [Researcher: What //would it have changed?] //Because it was all set up and it was you know, all the wards were covered, all theatres had been cancelled, it was ready to go and then they pulled out at the last minute. So again it was like "the nurses".[49]

A number of interviews were carried out with hospital nurses (see Appendix B for details) after the threatened strike in 1997 but before the national strike in 1999, and it therefore reflects this process of growing militancy. As the militancy of the nursing category increased, nurses criticised their union leaders for failing to match their new-found confidence:

[Researcher: How do you feel about what happened now, how do you feel about the process of the ballots? (pause) Do you feel the union represented you?] I think they did. I mean last year I was quite disappointed in them, before the strike, before we had the ballot on the strike. I felt that they were wishy-washy// [Researcher: //This is the leadership of the INO?] Yeah. I thought that they were letting the Department of Health away with a lot, and not really standing up... And then I think as nurses became a little bit more outspoken, they represented us better.[50]

In addition to the effects of health service rationalisation, the nurses' pay campaign also expressed the dissatisfaction of nurses with their salaries in the context of a rapid acceleration in pay increases in certain areas of private sector employment. Moreover, as economic expansion led to tighter labour markets, hospitals experienced difficulties with recruitment. This had a dual impact on the nurses' campaign: on the one hand, nurses gained confidence from their stronger labour market position, and on the other, hospital managers were more receptive to nurses' demands due to recruitment problems.

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[49] Female Staff Nurse (25 years of age) in *Voluntary Hospital*, Interview 1-5.
[50] Female Staff Nurse (31 years of age) in *Voluntary Hospital*, Interview 1-2.

However, there is a lot more to the militancy of nurses during this period than a sense of 'relative deprivation'. As I will show in Chapter Five, a range of non-pay grievances played a key role in stimulating militancy, and the union leadership essentially *channelled* the resulting anger towards wage increases. However, having 'taken the lid off the pressure cooker' in 1996 by calling mass meetings and balloting on strike action, the leadership of the general unions was determined to regain control. A full-time SIPTU union official made the following comment:

> *What initially was greeted as being you know, good progress by the activists on our union committees and so on, was then looked at by rank-and-file members, who basically, what they said was 'well Janey we're on a roll here you know like, let's keep going' and what became difficult at the end of the day was to get the genie back in the bottle. Now the problem with that is you might say 'well why try to put the genie back in the bottle?' But the difficulty is that, it was in the latter stage getting to – you know, this is a matter for... You know, you either feel like this is happening or you don't, and you miss the point of it – but you get to the point where you feel that public opinion supports you up to a certain length but could now turn. And there was comment beginning to creep in about 'you know, maybe this is pushing it a bit too far, it's a bit greedy or something'.*[51]

In contrast, the INO and the PNA seem to have been more aware of the mood on the ground, as the following two extracts, by Liam Doran (then Deputy General Secretary of the INO) and Des Kavanagh (General Secretary of the PNA) illustrate:

> *We had a motion passed at last week's conference that we are to convene a Special Delegate Conference in October to consider our response to the Commission on Nursing's final Report. If that doesn't realise the expectation in terms of pay, then we are to reactivate the deferred industrial action. So events may overtake us. We might have all our grand plans, all you like, but if the Commission doesn't come up with the goods in the end of July, then I think we will be back on a very slippery*

[51] Interview by the author.

slope with the nurses VERY focused, VERY informed and VERY aware of what the Commission was expected to do and what it may not have done.[52]

I mean I hear nurses in the General Nursing area talking about "the next pay increase coming up under the Commission". But there was no reference in the terms of reference to basic pay. ... Now I don't know to what extent – I'm on the Commission – to what extent the recommendations which may come forth in relation to allowances and differentials is going to improve things, and whether that would be seen as responding to the demands that are there for pay increases. But I would say that there's every possibility at the end of the Commission Report that the militancy will flow again, and that there'll be another debate. And again, I don't think nurses give a damn about whether or not agreements are there.[53]

A new claim for an increase worth roughly 18 per cent was presented at the beginning of 1999, and when the health service employers' agency refused to consider this, the issue was referred once again to the Labour Court. The claim was targeted at nurses at the top of the staff nurse scale and involved extra allowances and increased differentials far in excess of the 2 per cent increase provided for under the local bargaining clause of Partnership 2000. When the Labour Court published its recommendations in March 1999, nurses were incensed: the only demand that was accepted was for increased allowances, and the Court argued that all outstanding pay claims had been dealt with in 1997. The aim was clearly to defend Partnership 2000 and to avoid making concessions that might have knock-on effects. When balloted, nurses rejected the Labour Court proposals and voted unanimously for strike action, and the first national nurses' strike in the Republic began on 19 October 1999. After 9 days of all-out action, the Labour Court made a revised recommendation[54]. As soon as this offer was tabled, union leaders called off the strike and recommended acceptance. A large majority of nurses voted in favour

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[52] Liam Doran, Interview U-11.

[53] Des Kavanagh, General Secretary of the PNA, Interview U-13.

[54] The revised Labour Court recommendations provided for an additional 2,500 senior staff nurse posts, backdated to 5 November 1999, for nurses with 15 years' experience, at a salary 5% above the maximum staff nurse salary. It also created 2,600 promotional posts in line management and made improvements to pay rates for evening shifts and to the allowances paid to nurses in Psychiatry and Mental Handicap. The total package was worth an estimated 26%. During the strike, the Alliance dropped its demand for additional long-service increments and agreed to discuss how to 'recognise experience' instead.

of the deal, although a sizeable minority were once again critical of the leadership for having called off the industrial action so quickly[55].

It is interesting to consider the differences between the two 'exclusive' nursing unions – the Irish Nurses Organisation (INO) and the Psychiatric Nurses Association (PNA) – and the two 'general' unions – SIPTU and IMPACT – within the context of the nurses' pay campaign. On the surface, the divisions between these unions were set aside when they came together to form the Nursing Alliance at the beginning of the pay campaign. On closer inspection, however, considerable differences may be detected in their strategic outlook. As the militancy of General Nurses increased during the 1990s, the INO increasingly aligned itself with the PNA, which had withdrawn from ICTU in 1992 in order to adopt a more aggressive recruitment campaign. The PNA's autonomy from ICTU enabled the union to express nurses' frustrations with 'Partnership', and its membership almost doubled between the late 1980s and the late 1990s. Des Kavanagh, General Secretary of the PNA summarised his union's stance in relation to centralised agreements:

> *Well you see, in the normal course of events, if we were starting from a position where nursing pay and conditions were reasonably equal... or where there was an equity about nurses' pay and conditions, I would say that my job, I'd have a responsibility for ensuring that people comply with the agreements that are reached. (pause) But I'm pragmatic enough (laughs) and probably cynical enough to say "Well I have no embarrassment about using the militancy of our members and the militancy of the INO to improve the value of the profession overall". And if that means... I mean, if our members and the members of the INO come on the streets and come to meetings to a point where they are telling us that they are committed to improving on their present package, and that they want leadership in doing it, then I'll provide the leadership and [And that's your job]. And if I'm going to be in breach of whatever national agreement, then so be it.*[56]

The attitude of the INO to 'Partnership' is quite similar to this, as the following extract indicates:

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[55] The vote was as follows: INO: 73% in favour; SIPTU: 63%; IMPACT: 82% and PNA: 72%.

Well our approach to PCW was quite simple: the PCW set a local bargaining clause of 3%, right, in the context of "3% and any other improvements had to be met with productivity". We argued from day one that essentially, from a nursing perspective, productivity – you were having it, you were getting it, per man-hour you were getting it from nurses, you had got it in the previous number of years and now it's pay-back time.[57]

Although the INO remains affiliated to Congress, its exclusive focus on nurses and its small size means that it is also relatively 'immune' to pressures to conform to the terms of national agreements. Thus, the increased independence of the INO from health service management and the greater willingness of INO members to consider industrial action provided the PNA with a key ally in pursuing some of its strategic aims.

On the basis of this brief overview of the 'professional' nursing unions in Ireland, it is possible to draw parallels between the stance of the PNA and the INO, on the one hand, and category-based unions such as the FAPAS in Italy, which organises nurses, paramedics and a number of allied professions, on the other. The FAPAS is not to be confused with 'rank-and-file' unions such as the Cobas, but it – like the INO and PNA – nevertheless plays a similar role within the industrial relations system by providing a channel for nurses' grievances and forcing the general unions to take these issues on board. Because of the impact of membership levels on the power and influence of the unions, the threat of losing members to a more radical rival has the ability to galvanise even the most conservative union officials into action. In fact, once SIPTU and IMPACT had allied themselves with the INO and the PNA, they were forced to follow what was arguably the more militant line of the two smaller professional unions. The following comment by one of the leaders of the two general unions clearly reflects this tension:

Personally I wasn't happy with the way submissions were written, I wasn't happy with the way things were done, but we are part of the Alliance and really you could only just have your say and hope that people would listen. But when I saw people

[56] Des Kavanagh, Interview U-13.

looking for three long-term increments of 6% each and all of that, that's raising expectancies so high that I don't think we can deliver. We can deliver and we can get something for nurses but the reality is going to be so far from the expectancy that I don't know if they will bring themselves down that far. So I think that is going to be a major problem and that has been created by the unions themselves. It is something that we have specifically not done, and it is something that we have gone around the country and told the nurses, "For God's sake, don't expect so much".[58]

It is also important to stress that the main beneficiary of the pay campaign was the INO, which, as the main nursing union in Ireland, increased its membership from roughly 17,000 in 1996 to 24,000 at the end of the campaign (an increase of more than 40%). Although the other unions also made gains, they were of a much lower order. This helped to convince the INO leadership, despite its hesitancy at the beginning of the pay campaign, that a militant stance could yield large dividends without necessarily incurring sanctions:

Yeah, nursing is trying to play catch-up and nurses are trying to play catch-up. You can look at the 39 hour week. Most officer grades have a 35 hour week. You can look at the annual leave allowance, it's 2 or 3 days less than comparable grades. We are trying to play catch-up on a lot of fronts... Despite what people might think – that was a big war – in my view, that was only a skirmish, what we had. And I think it will be a 10 or 15 year process before we make up the 100 years of lost ground. I know that sounds very grandiose, it's not meant to sound that way, but in my view it's just a hard fact of life, we are now on the upward slant of a 10 to 15 year movement, which will HAVE to secure more resources for nurses.[59]

Before moving on to assess the stance of SIPTU and IMPACT in relation to centralised agreements, it is worth noting that throughout the pay campaign, and during interviews with the author, neither the INO nor the PNA expressed an explicitly critical stance in relation to the financial and organisational aspects of health service rationalisation.

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[57] Liam Doran, Interview U-11.
[58] Interview by the author, early 2000.
[59] Liam Doran, Interview U-11.

Instead, they tended to take these changes for granted – or at the very least to assume that there was little that they could do to obstruct them – and to translate nurses' *non-pay* grievances into a set of demands for increases in remuneration.

At the beginning of the pay campaign, union officials had the impression that health service administrators did not have a coherent strategic plan for the service as a whole. As I showed in Chapter Two, the progress of the rationalisation process was more incremental and uneven than in Italy. Nevertheless, the cumulative effect of this process has had a dramatic impact on the health service, particularly in relation to staffing, funding and management. However, because of the decentralisation of decision-making, it was difficult for the unions to develop a clear picture of the effects of rationalisation at local level, and the relative weakness of the branch network of the INO, in particular, created considerable difficulties. It is evident that the separation between the 'economic' and the 'political' spheres is rather sharper in Ireland than in Italy, with the result that Irish union leaders (and their members) tend to view health policy as the preserve of government, their own role being to defend members' interests within that framework.

The PNA, which is more strongly rooted at local level, has attempted to defend staffing levels and to oppose certain aspects of the rationalisation process: "I mean the impression we have is that most of the health services are locally-driven and ad hoc, as opposed to operating under a central thesis. You know, there's no evidence of a grand plan that's being followed. Except, I mean, OK you could say under *Planning for the Future*, which was the... In Psychiatry the intention was to reduce hospital numbers and create a range of services in the community. I mean, that has been done. But of course that's where it stops. I mean you can see there a policy, a national policy. But its implementation is hugely *ad hoc*... If there's a common factor throughout the whole lot it would be to achieve as much community development at the lowest possible cost. So most of the negotiations are based on Health Boards trying to achieve the changes without increasing staff numbers, and if at all possible to try and to reduce them. And our battle has been at the very least to maintain our numbers, and that's a constant battle, you know"[60]. I will return to this issue in Chapter Five, where I will provide a

[60] Des Kavanagh, Interview U-13.

detailed discussion of nurses' work grievances, and in Chapter Six, where I will explore how these issues are interpreted by union representatives.

The most important aspect of the strategic outlook of SIPTU and IMPACT, as far as health service rationalisation is concerned, is obviously their role in supporting and defending concertation at national level:

> *So one thing about central bargaining is that you can influence increases in pay. You CAN influence taxation, as we did: we influenced the amount of money, but this time not the way it was spread. And so it's a compromise always of course. It's, you know, do you trade this off against something else? Like national bargaining has bad effects for us as well, that I think maybe even at the end of this one, even if we could look back and say – and we can look back and say historically – that if you look at what's happened over the last ten years we can say that in many respects we've done better than we would under a free-for-all situation.*[61]

Nevertheless, as part of the Nursing Alliance, these two unions participated in the nurses' pay campaign, which represented one of the strongest challenges to 'Partnership'. The most important conclusion to be drawn from this is that it demonstrates that it is possible for militant groups of workers to force their union leaders to call industrial action and to win major gains, regardless of the existence of national agreements. IMPACT, the union with the smallest number of nurse members, is in many ways similar to SIPTU in terms of its relationship to central agreements, which is overwhelmingly positive, despite some reservations in relation to the rigidity of the system of relativities that underlies 'Partnership': "The main pay-off I would think, in relation to Partnership, is that we have for the first time achieved a say in what used to be the sole preserve of the Government, and that is you can actually influence the level of overall taxation. You can also influence the other kind of imponderables that you couldn't even touch such as mortgage interest rates and interest rates generally"[62]. Like SIPTU, IMPACT emphasises the 'professionalism' of its union

[61] Noel Dowling, General Secretary of SIPTU Nursing, Interview U-12.
[62] Kieran O'Driscoll, General Secretary of the Health Services division of IMPACT, Interview U-8.

negotiators, and has a favourable attitude towards public sector 'modernisation' and rationalisation:

> *I have the view myself that unless trade unions are out at the leading edge of change and improvement of service delivery, and that includes flexibility and it includes realising that the clients are also the pay-masters. And that the day when you can simply demand higher pay and the only basis on which you advance that demand is that if you don't give it to me, we'll stop giving you the service has gone.*[63]

Kieran O'Driscoll (General Secretary of the Health Services Division of IMPACT) links the frustrations of nurses during the 1990s with the rigid occupational hierarchies that continue to dominate the public sector, emphasising the importance of the Commission on Nursing in opening up new avenues for the promotion of professionally-motivated nurses. This clearly corresponds to a less 'industrial' and more 'professional' approach to union representation, which is echoed in IMPACT's internal structure, which seeks to provide an outlet for the 'vocational' aspirations of public sector employees as well as their demands in relation to pay and conditions. To this extent, a comparison may be drawn between IMPACT and the Italian UIL, which explicitly identified itself as 'the citizen's union' towards the end of the 1980s.

Summary

In this chapter I described the evolution of union representation in Ireland and Italy over the post-war period and I provided a comparative analysis of the emergence of neo-corporatist bargaining arrangements in these two countries. Drawing on the industrial relations literature, I linked this process with the difficulties faced by countries in the periphery of the European Union in meeting the requirements of Monetary Union. Thus, the findings of the research confirm the usefulness of a comparative approach that focuses on peripheral regions within the European Union. As in Chapter Two, the main observation made in this chapter is that strong similarities are observed in relation to the

[63] Kieran O'Driscoll, Interview U-8.

behaviour of key social actors in Ireland and Italy. I argued that the demands of European convergence and the 'modernisation' of state welfare services coincided with severe economic crises in both countries, and this conditioned union responses to health service rationalisation. Against this backdrop, it is perhaps unsurprising that the 'social pacts' negotiated in Ireland and Italy in the late 1980s and early 1990s were strongly 'neo-liberal' and deflationary in character. Thus, the unions' adherence to these agreements engineered their agreement to the overall terms of health service rationalisation. This is why Prondzynski (1992) concludes that:

> *The PNR was to run side by side with a government programme of massive cost-cutting in the public sector, as well as a number of other measures to depress inflation and cut the budget deficit, which might, in earlier times, have met stiff trade union resistance... in practice the PNR locked the trade union movement into an alliance with the government which made difficult any serious opposition to other aspects of government policy.* (Prondzynski, 1992: 81)

The participation of the largest union organisations in national agreements has led to similar tensions within the union movement in both Ireland and Italy, although the strategy adopted by union leaders was contested much more strongly, explicitly and quickly in the latter case. This is attributable to the presence of union actors outside the historic confederations which are opposed to concertation. Furthermore, union activists within CGIL, CISL and UIL could draw on political traditions of collectivism and militancy associated with the experience of the 'hot autumn' in constructing a rank-and-file protest movement in Autumn 1992. This forced the union confederations to call strikes in protest at the introduction of health charges and the cuts in funding announced in 1992 and 1993, although the reorganisation of the health service that followed met with little resistance. The only unions that were consistently critical of the health service reforms were the rank-and-file unions, but as I will show in Chapter Six, these unions did not have the support necessary to challenge the process of rationalisation.

In contrast, the Irish unions posed little resistance to the cuts made in health expenditure, hospital beds and staffing levels in 1987, and this decision was not contested by a significant section of the union membership. This clearly reflects

differences in the political and organisational traditions within the Irish union movement, as compared to Italy. But the timing of the Irish cuts is also significant: in 1987, the Irish labour movement was arguably at its weakest point in almost thirty years and very few union militants espoused an explicitly class-based, antagonistic approach. However, the nurses' pay campaign during the mid-1990s and the first national nurses' strike indicated that a considerable change in the mood of public sector workers had taken place since 1987. I will return to these issues in Chapter Six, where I will analyse the outlook and behaviour of *local* union representatives and provide a theoretical explanation for the most important commonalities and differences between nurses' responses to rationalisation in Ireland and Italy.

IV MANAGEMENT STRATEGIES AND CONSTRAINTS IN THE IRISH AND ITALIAN HEALTH SERVICES

Introduction

In this chapter I will examine the responses of local managers and health service administrators to health service rationalisation in Ireland and Southern Italy during the 1990s. As I showed in Chapter Two, managerialism has played an important role in health reform in both Ireland and Italy, involving the creation of an autonomous management function within the health service which is subject to performance evaluation and incentives. The role of this new form of management is ostensibly to apply innovative practices and to provide strategic direction. The main inspiration for managerialism in both countries appears to originate with the concept of 'new public management' (see Chapter Two). This has been accompanied by an ideological offensive which emphasises managerial prerogatives, the centrality of the service user and the need for flexibility and adaptability on the part of health workers. Hospital managers are instrumental to the implementation of the health service reforms as legislative changes are conditional upon the agency of local actors. For this reason, I will provide a detailed analysis of management strategies in this chapter, situating these in relation to the rationalisation process, on the one hand, and the social and political context of health service management, on the other.

To my knowledge, no detailed analysis of managerial responses to rationalisation has been provided in either Ireland or Italy, although a number of books dealing with the legislative changes introduced during the 1990s have appeared (Robins, 1997; McAuliffe & Joyce, 1998; Leahy & Wiley, 1998; France, 1999; Giorgetti, 2000; Pichelan, 1997; Mapelli, 1999; Zanetta & Casalegno, 1997). Although this research project was designed primarily with a view to studying union responses, the interview material collected by the researcher also provides information on management strategies. Although only four hospitals were studied and just seven managers interviewed, the possibility of drawing on a larger pool of interview material enables me to provide an interesting account of the outlook of hospital managers in Dublin and Naples. The value of this analysis is enhanced by the fact that the case study hospitals

are situated at the apex of the health service, providing employment to large numbers of health workers. Because of their economic significance and their importance for the public sector unions, the rationalisation process has focused primarily on *these* hospitals in its attempt to obtain efficiency gains. It is therefore of considerable urgency to assess whether the restructuring of health care has actually influenced the composition of the managerial stratum and managers' self-understandings as well as their attitudes towards patients and health workers.

The Social Context of Public Service Management in Ireland

I referred in Chapter Two to the legacy of late and uneven economic development in Ireland and Southern Italy and linked this with the notion of a 'particularistic-peripheral' welfare regime. This is of great relevance to the analysis of management strategies, as the relative weakness of the state engendered by late and uneven development renders public sector managers and administrators more vulnerable to powerful particularistic influences such as political clientelism. I will therefore begin this chapter by comparing the influence of particularism on management decision-making in Ireland and Italy. Basil Chubb (1963) provides one of the earliest scholarly discussions of Irish clientelism, and his 1970 textbook on Irish Government defines politicians as those who 'go about persecuting civil servants' on behalf of their constituents. This interpretation is echoed by Higgins (1982):

> *For generations, Irish people saw that to get the benefits that public authorities bestow, the help of a man with connections and influence was necessary. All that democracy has meant is that such a man has been laid on officially, as it were, and is now no longer a master but a servant.* (Higgins, 1982: 114-115, quoted in Hazelkorn, 1986: 329)

In their contribution to the literature on political clientelism in Ireland during the 1970s, Gibbon and Higgins (1974) linked clientelism with Ireland's experience of late and uneven development, suggesting that this led to a poor dispersal of wealth and a disproportionate reliance upon the state. The relatively poor level of service provision

and lack of integration encouraged citizens to seek a particularistic solution to their problems:

> *While the majority of queries concern housing, they also involve health benefits, employment and education. The introduction of examining boards in the late 1920s for public sector employment eliminated the worst excesses of jobbery, but political ties are still important and publicly visible, especially for public sector promotions. It is, to a very large degree, a moot point whether the patron's intervention actually produces the desired results; the crucial factor is less the immediate benefit than the long-term relationship.* (Hazelkorn, 1986: 336)

Hazelkorn argues that the ability of Fianna Fáil to exploit aspects of the socio-economic structure in order to seek electoral advantage encouraged its main rival, Fine Gael, to construct its own clientelistic electoral machine. Nevertheless, she warns against assuming that economic development has eroded Irish clientelism as a result of 'modernisation'[64]. Instead, the weakness of the Irish Labour Party and the polarisation of electoral competition between two right-wing parties has facilitated the vertical integration of the working class and led to the persistence of clientelistic relationships. Finally, Hazelkorn (1986) rather intriguingly suggests that Irish clientelism frequently involves collective forms of co-optation as well as the incorporation of individuals.

Allen (1997) questions the conclusions of Hazelkorn and the other authors discussed above, arguing that they misconstrue the social basis of support for Fianna Fáil:

> *The image of a patron-client relationship conjures up an extraordinary level of dependency for the services on offer. Fianna Fáil might have been able to tell individuals that they were getting a local authority house, but there was no guarantee they would vote for the party at the next election. Higgins and Gibbon's assumption that near 'feudal relations' persist in the present mode of capitalist production seems, at best, exaggerated. Contrary to the sometimes impressionistic local studies, there is some evidence to suggest that clientelist networks are not nearly as widespread as was assumed.* (Allen, 1997: 5)

Because the writings of Hazelkorn, Gibbon and Higgins are rather dated, I will draw on a number of interviews with health service managers and administrators in order to evaluate this issue. The evidence from the interviews indicates that the logic of clientelism, whilst continuing to exercise an influence on the Irish health service, does not dominate decision-making processes to anything like the same extent as in Southern Italy. Moreover, it would appear that managerial and clinical decision-making processes have become increasingly autonomous in recent years:

> *[Do you get a lot of contacts from politicians?] Oh I do. We would get quite a bit. But what we've always done at my level, in a hospital of this size... I would say that people at our level now, in the major hospitals, people would not be phased by a Minister. … Like Councillors, I had a guy ringing about A&E. And I said "hold on a minute, what do you think we're doing here?"*[65]

When pushed to elaborate on his attitude towards attempts by politicians to influence managerial decision-making, this manager nevertheless added some important qualifications:

> *And of COURSE I'm not saying I won't be influenced to try and support... But I DON'T think that we should run a service that's totally based on "because Senator so-and-so, or a Councillor said". We have to get away from that, because that was the old days, and I think that if we can base it on clinical decision-making that is fair and equitable, then I think everyone gets the best. I DO think we need our politicians to set the goals. But I also think that we shouldn't be using the health system as a voting system.*[66]

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[64] "[t]he increasing dominance of the capitalist mode of production in Ireland has not been accompanied by any noticeable weakening in clientele ties" (Hazelkorn, 1986: 339-340).
[65] Chief Executive Officer of *Voluntary Hospital*, Interview M-3.
[66] Chief Executive Officer of *Voluntary Hospital*, Interview M-3.

The Social Context of Public Service Management in Italy

As in Ireland, the main contributors to debates about clientelism in the South of Italy – Sidney Tarrow, Percy Allum and Judith Chubb – share a political science background and a commitment to a qualitative and historical approach. By looking at their conclusions, it is possible to clarify some of the similarities and differences between Irish and Italian clientelism. Allum (1973) bases his analysis of clientelism in Naples on Tönnies' distinction between social relations which may be categorised as *Gemeinschaft* (where other individuals are seen as an end in themselves) and *Gesellschaft* (where others are considered only as a means to some extrinsic end), arguing that the imposition of an essentially bourgeois political system upon a 'backward' South reduced the *Mezzogiorno* to the position of a colony within an imperial country, enabling parasitic intermediaries to monopolise the interstices between these two contrasting systems of social organisation. Thus, the connection between this theoretical framework and the economic marginality of Southern Italy is clear, although it arguably rests on an over-simplification of the relationship between economic 'backwardness' and political clientelism.

Judith Chubb (1982) suggests that Italian clientelism has given rise to an elaborate system of winning and maintaining power on the part of an urbanised, mass party – the Christian Democrats – and that this distinguishes it from the clientelism found in predominantly rural countries. As in Ireland, a populist 'Catholic' party was able to dominate the political system by exploiting lengthy periods in office and establishing a resilient clientelistic machine. This structure has remained highly resilient, even in the face of the realignment of the political system and the rationalisation of the public services.

Chubb revises the traditional understanding of clientelism as requiring an expanding 'downward distribution of resources', pointing out that the Italian DC was able to hold onto power by means of a 'skilful manipulation of scarcity' and by controlling the state bureaucracy. She also emphasises the reactionary consequences of clientelistic political structures, which "limit socio-economic change within boundaries that do not threaten political control over essential resources, as well as perpetuating a society constructed

on the exacerbation of individual privilege on the one hand and on mass deprivation and collective squalor on the other" (1982: 252).

The principal beneficiaries of clientelism, according to Chubb, are politicians themselves, who defend their position by frustrating autonomous forms of economic development. This gives rise to a vicious circle, as economic growth is allegedly the only force that can undermine the social basis of clientelism. This is why Chubb concludes that only the election of a left-wing government at national level can provide the conditions for overcoming clientelism in the South of Italy. However, rather than *assuming* that Southern Italian clientelism expresses the dominance of the political over the economic sphere, it is arguably more productive to explore the nature of the relationship between economic interests, political actors and the state (cf. Behan, 1996; Barbagallo, 1997, 1999). Not only can this shed light on the role of the public services in Southern Italian society and the constraints that this places on hospital managers, but it can also reveal the conditions for the existence of clientelism.

Health Service Rationalisation: Managerialism

Before providing an empirical analysis of management strategies in the Irish and Italian health services, I will provide a more detailed description of 'managerialism'. This entails the application of management techniques originally developed within the private sector, and sometimes involves an attempt to import *managers themselves* from the private sector. However, in Italy, where this attempt was most marked, very few private sector managers have joined the health service:

> *Today, in the health service, 95 per cent of the managers come from within the health service itself – they are the former administrators who have become the new 'managers' even though they do not have the slightest idea of what management is about.*[67]

[67] General Manager of *Azienda*, Interview M-1.

In relation to the role of management, it is important to appreciate that managerialism is not concerned solely with 'technical' issues, but also has implications for the balance of power within the hospitals. The competitive restructuring of the health service in the advanced capitalist countries during the 1990s has involved a strengthening of managerial authority within the hospital service and an increase in the efficiency of public health care:

> *The General Manager also does these kinds of things: he intervenes, he walks around the hospital – often on his own, without making a big deal out of it. As a result, the staff find him looking over their shoulder and they don't even know how he got there! He likes to control certain situations personally. At any rate, he has transformed the situation in this enterprise, and it is all thanks to him. If we are reaching a level of productivity envied by all it is only thanks to his management style. He has achieved considerable results – albeit with a degree of toughness.*[68]

I will return to this issue from the perspective of nursing staff in Chapter Five. It is worth pointing out, however, that there are considerable limitations to the ability of hospital managers in Italy to adopt a private-sector management style, due to existence of administrative and legislative regulations in the public sector. For example, a General Manager can only use his or her discretion in relation to purchases under about €15,000 (even where he or she is responsible for a budget of €300 million or more). For all other purchases, tenders must be sought according to a complicated and bureaucratic procedure designed to avoid corruption[69]. Even this freedom is limited to the *Aziende ospedaliere* (equivalent to Trust Hospitals or Voluntary Hospitals), as those in charge of directly-managed facilities have even less autonomy. In Ireland, in contrast, the autonomy of the Voluntary Hospitals is much greater and accountability is ensured retrospectively by scrutinising financial accounts (see Chapter Two).

In addition to its technical, social and organisational aspects, managerialism also entails an ideological offensive within the health service, with the aim of altering the balance of power between managers and employees and fostering new managerial self-

[68] Female Unit Nursing Officer in *Azienda*, Interview 2-1.
[69] However, to the extent that rival firms are prepared to co-operate in order to subvert the law, even these restrictions can be overcome.

understandings. Clarke and Newman (1997) trace the origins of current managerial ideologies to the response of the American economic elite to the competitive threat posed by the Asian 'Tiger' economies during the 1970s. The main effect of these ideologies is to foster hysteria about the danger of being 'left behind' by change, about 'missing the boat' and becoming 'extinct' in the battle for economic survival. This is linked with an 'us and them' ideology of the national 'ship' afloat in hostile seas (competitive international markets): a unifying discourse of the nation is proposed in articulation with the battle for survival.

The distinction between the role of managers, specific managerial techniques and the diffusion of 'managerialist' ideologies highlights the importance of studying the response of hospital managers to health service rationalisation. The application of managerial techniques and the diffusion of new models of management are conditional upon the agency of local managers, without whose support managerialism remains ineffectual. British debates about the NHS reforms have paid considerable attention to the internalisation of managerial ideologies by health service managers, and commentators have described managers variously as 'cowboys' who face down their adversaries, as 'cost accountants' driven purely by financial motives and even as the 'new Bolsheviks' whose only certainty is 'the need for change' (Clarke & Newman, 1993).

In overall terms, managerial responses to rationalisation have been much more favourable in Ireland than in Italy. A high degree of consensus has been obtained around the need for efficiency gains and most managers seem to subscribe to the new agenda:

> *[Researcher: ...how do you see, across the board, the responses of the CEOs in the different hospitals, particularly in the acute sector, to this sort of new agenda about management?] I think overall they've reacted very positively to it. I think all of them would realise... In fact some of them were arguably the front-runners in it.*[70]

[70] Mr. Gerard Barry, CEO of the Health Services Employers Agency, Interview M-4.

This consensus must be attributed, at least in part, to the incremental approach adopted by the Irish government during the 1990s and to the structure of the Irish health service. This does not imply that there are no obstacles to rationalisation in Ireland, as alternative administrative approaches can also be detected. For example, a bureaucratic culture of 'compliance' predates the current concern with 'dynamic' and 'strategic' management. Although this has ensured a positive response to legislative change in Ireland, it is hard to see this as favouring innovation:

> *... there's a long tradition of compliance within the health service. I mean the health service was under Local Government administration until 1970, then we had the creation of the Health Boards. But even the legislation that established the Health Boards was grounded in Local Government administration, which goes back to the forties. And administrative compliance was the ethos.*[71]

It is also important to recognise that the religious orders have contributed to a 'caring ethic' within hospital management in Ireland which contradicts a strict 'cost accounting' approach to management. Although there are anomalies in relation to this 'caring ethic', in the sense that the Voluntary Hospitals continue to provide an inequitable, two-tier form of health care, and have demonstrated their willingness to implement tight financial controls (see Chapter Two), this must nevertheless be considered an alternative form of managerial rationality. The culture of 'administrative compliance' and the 'caring ethic' come together in a system that revolves around the dominant role of the medical profession. The CEO of the Irish case study hospital, which I will refer to as *Voluntary Hospital*, mentioned that when he was first appointed, "the Consultants made the decisions and the administrator basically just did what he was told"[72] (see Appendix A for an overview of how the case study hospitals were selected and Appendix B for a description of the interviewees and the methodological approach adopted).

Attitudes towards managerialism in Italy have tended to be much more polarised than in Ireland, with a much lower level of compliance due to the predominance of alternative

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[71] Mr. Gerard Barry, Interview M-4.
[72] Chief Executive Officer of *Voluntary Hospital*, Interview M-3.

managerial motives. Despite the apparent radicalism of the health reforms of 1992-93, little appears to have changed in relation to the composition of the management stratum:

> *Many of those working in the National Health Service, at least judging from their silence in this respect, appear to view the pro-competition reform as a problem which can best be tackled by pretending that it will never be implemented.* (France, 1997: 87)

This quotation provides an accurate summary of managerial attitudes towards rationalisation in Southern Italy, as the incompetence[73] of many managers is matched by their allegiance to a culture of administration which is at odds with the managerialist thrust of the health reforms. The prevalence of a strategy of 'passive resistance' is illustrated by the slow pace of change, the failure to publish a breakdown of staffing levels (the so-called *Pianta organica*) and the reluctance to adopt 'modern' accounting techniques and other elements of the reforms. This resistance is due in part to the vested interests of managers in concealing improprieties in the deployment of hospital personnel and in spending decisions. It is also pertinent that hospital managers in Southern Italy have traditionally lacked authority, because they owe their appointment to a political party:

> *... previously a postman might have ended up as President of the Board of Management. In other words, a respectable man who had delivered the post all his life, and who now became President of the LHU*[74]*. Without taking anything away from postmen, the problem was that the nominees to the post of President of the Board of Management of the LHUs were often unsuccessful candidates in various electoral contests – local, regional etc. – who were nevertheless 'vote-carriers'.*[75]

[73] As I pointed out in Chapter Two, the appointment of hospital managers has been strongly influenced by political and clientelistic criteria, which has led to the influx of relatively incompetent managers.
[74] LHU is short for Local Health Unit, which is how I have decided to translate *USL* (*Unità sanitaria locale*) and *ASL* (*Azienda sanitaria locale*).
[75] Manager of a Local Health Unit in Southern Italy, Interview M-2.

In Southern Italy, the appointment of a hospital manager is typically subject to partisan political considerations at regional level, and this tends to favour individuals with political links. The situation in the past was characterised by explicit political control, as a union representative recalls:

> *We have come from a type of health organisation where the management of the hospitals was of a political nature. The unions could influence even the nomination of the President of a hospital, who was nominated by a party. We had links with the party and we were easily able to influence their choice. Therefore the role was clear: a President arrived because he corresponded to certain political interests.*[76]

This situation has not changed dramatically in recent years, despite the emphasis on managerialism within the Italian reforms. Practically all recent managerial appointments to the Southern Italian health service are 'political' in nature. Nevertheless, for a brief period in the mid- to late-1990s a more dispassionate approach was promoted by the Centre-Left administration in the Region of Campania, and a small number of relatively autonomous and independent managers were appointed, including the General Manager of the first Italian case study hospital, which I will refer to as *Azienda* (from *Azienda Ospedaliera*).

It would nevertheless be incorrect to suggest that political interference in the management of the health service has given rise to a layer of 'political pawns'. The fact that many managers have responded to the health reforms by adopting a strategy of inertia and obstructionism does not imply that they are not strategic actors in their own right. On the contrary, the unpredictability of their environment and the intractable nature of many of the problems in the Southern Italian health service have encouraged managers to focus their strategic capacities on areas *not directly related to the provision of health care*. In fact, the relationship between politicians and managers has enabled some managers to develop their careers by becoming strategic actors at a political level. The dependence of public sector management on political patronage means, above all, that managers are subject to clientelistic interventions and political intrusions:

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[76] Male Staff Nurse (*Infermiere Professionale*) (32 years of age) and union representative in *Azienda*, Interview 2-21.

[Researcher: What about your autonomy in relation to the political sphere?] What do you think? [Researcher: I haven't a clue, I can't make out what happens beneath the surface. In my opinion, you have a certain autonomy, although I would have my doubts in other cases.] And that's the way it is. That's also why I will not stay on in the health service. The next appointment will be made at the end of '99, beginning of 2000, because my five-year contract expires, and it's a political choice. Either you step into line beforehand or you don't get appointed. So I prefer not to participate.[77]

The focus of political clientelism is obviously the vote relationship, and when I state that health service managers in Southern Italy are subject to clientelistic interventions, I mean that they follow the logic of clientelistic political exchange. This implies that the resources of the public hospitals and the discretionary power of public sector managers are mobilised in order to gather votes. In such a system, hospital managers derive their power primarily from their relationship with individual politicians, rather than with individual voters. It is this exchange relationship that enables managers to pursue their political and career aspirations independently of their achievements within their own hospitals. There is therefore a qualitative difference between the clientelism found in Irish and Italian hospitals. In the latter case, clientelism permeates the managerial stratum as a whole and the logic of vote-collecting embraces managers themselves.

In Ireland, although certain politicians may continue to operate in a clientelistic fashion – promising to help their constituents to obtain preferential treatment within the health service, for example – the greater independence of hospital managers (who are appointed by a Board of Directors in the case of the Voluntary Hospitals, and not by the Health Boards) has enabled them to distance themselves from this logic of public service management.

[77] General Manager of *Azienda*, Interview M-1.

Methodological Considerations

One of the difficulties that one faces when studying managerial strategies is that most managerial decision-making takes place behind closed doors and those involved often have an interest in concealing the outcomes of this process. Managers typically avoid giving direct expression to their intentions in order to avoid challenges to their leadership and so that they can alter their approach in a flexible manner in accordance with the circumstances. Moreover, the management function in a public hospital involves more than just one person, and internal conflicts can therefore develop. Not only this, it can often be difficult to identify those responsible for specific decisions. There is thus a gulf between the articulation and implementation of strategies, as Crow (1989) observes, and this implies that the conscious, comprehensive and rational strategies which one may be tempted to ascribe to managers (Wood and Kelly, 1982) may be the outcome of a series of contingent circumstances involving many opposing perspectives, none of which is realised in full (Clarke and Newman, 1993; Crow, 1989).

A further difficulty is that management strategies become steadily more opaque as one reaches the local level. Whereas government ministers and senior administrators produce formal policy documents and circulars which give expression to their strategies, one must interpret managers' strategies on the basis of the observed effects of their interventions. For example, the allegation of managerial clientelism in relation to promotions and appointments can only be made on the basis of an analysis of the actual distribution of personnel within the hospital and by excluding alternative hypotheses. This is obviously a difficult task, and gives rise to a serious risk of misinterpreting the intentions of the actors concerned. Managers' strategies are not only "composite, mixed and even contradictory" (Littler, 1982: 42), but also, in an environment which is highly unpredictable and contested by numerous actors, it may not even make sense for individual managers to behave strategically.

The concept of 'strategic management' also raises important issues in relation to the structure/agency dichotomy in social science. Whilst emphasising agency, the rather 'military' metaphor implicit in the notion of 'strategy' also embraces the 'positioning' of actors within structured environments, and may therefore enable researchers to theorise the relationship between social structures and individual agency. Although it is

possible to shed light on managerial decisions by contextualising them carefully, one must be aware that 'strategies' are not the only causal forces in operation. Above all, 'strategic analysis' does not substitute for substantive social theory; the constraints imposed by social structures may be said to operate through the active involvement of agents and the differential distribution of resources and power.

The opinions of agents who are in close contact with managers provide a useful resource in the investigation of managers' strategies, as they are typically more forthcoming than senior managers themselves. For example, union representatives and middle managers are often in a position to develop a well-informed opinion about the intentions of senior managers, although naturally there are no guarantees that they will always be correct. In the context of an anonymous interview, some managers may speak openly about their aims, although it can be extremely difficult to gain access to senior staff. This is particularly true in Southern Italy, where managers rarely respect appointments and where long queues develop outside the office of the General Manager as people await the possibility of a meeting.

In the empirical analysis of local management strategies, the conceptual approach described by Baeza, Salt and Tilley (1993) is extremely useful. These authors suggest that we should begin by identifying the most important subjective features of a manager's environment before investigating his or her strategic preferences in the context of established management practices and organisational factors. After identifying these key elements, we should examine the most important external and internal factors that influence the outcomes of managerial interventions. For example, we might consider the mechanisms that constrain or enable the straightforward achievement of a manager's primary goals. Then, in iterative fashion, we revise our view of management strategies in light of our developing ideas about the social context. For example, we might come to view a specific strategy as a pragmatic response rather than as an expression of a manager's primary goals (e.g. as Crouch (1982) suggests). This method is helpful when analysing management strategies, as it renders explicit the iterative revision of hypotheses inherent in empirical research.

Management Responses to Rationalisation in Ireland and Italy

First Case Study Hospital – *Voluntary Hospital*

In the following paragraphs, I will examine the attitudes and behaviour of managers in one hospital in Ireland and in two hospitals in Italy, as well as referring to interviews with a representative of the Health Service Employers' Agency in Ireland and with managers from two Local Health Units in Italy. The first hospital that I will discuss is a large Public Voluntary Hospital situated in Dublin (*Voluntary Hospital*). This hospital is run by a religious order, but is funded primarily by the Irish state. Prior to the recent health reforms, the Public Voluntary Hospitals received a block grant directly from the Department of Health, calculated on the basis of historic spending levels. The funding system has now changed, as I outlined in Chapter Two, and the Voluntary Hospitals receive their funding directly from the Health Boards (or Health Authority in the Eastern Region) on the basis of a combination of historic spending, their 'caseload' and their efficiency.

This hospital carries out both emergency interventions and elective admissions, including complex surgical procedures and treatments. It contains both 'public' and 'private' beds and the religious order which owns the hospital also maintains a private hospital nearby. As in *Azienda*, a new manager was appointed in the early 1990s, and set about reorganising the hospital in the light of the health reforms. The Chief Executive Officer (CEO) of *Voluntary Hospital* enjoys a relatively high level of autonomy and espouses a 'professional' and 'innovative' approach to public sector management.

Voluntary Hospital is a specialist centre of national importance which performs a number of complex medical procedures, and hence the subjective environment of the CEO was shaped by the need to defend and expand this role. The main feature of this environment in the mid-1990s was the hospital's lack of control over patient flows. Because of the cuts in the number of hospital beds in the Irish health service during the 1980s, patient throughput increased rapidly, and this absorbed the hospital's spare capacity:

> *Throughput has most definitely gone up. Oh yeah. I think in fairness the pressures... More beds were taken out of the system. Sorry, I should clarify this. More hospitals were taken out of the system. In Dublin alone there's two and a half thousand beds less, compared to a number of years ago, so taking total numbers... Where the hospitals are left open, there's more nurses, but I think in the TOTAL system// [Researcher: //There's more volume going through?] There's FAR more volume going through.*[78]

Because the hospital was operating at full capacity, the scope for strategic management was rather limited – particularly because of the Senior Consultants' control over day-to-day resource utilisation. This posed a threat to the hospitals' long-term development by making it difficult to increase the share of 'high-value' procedures in its overall workload. The main strategic aim of the CEO was therefore to increase the hospital's influence over *other* actors within the health service in order to influence patient referrals. Patients enter Irish hospitals primarily as a result of either *medical referrals* or *emergency treatment*, and the strategies of the CEO focused on these two avenues. Thus, the main external constraint on the ability of management at *Voluntary Hospital* to achieve their goals was the nature of medical decision-making ('clinical autonomy') and the main internal constraint was the demand for Accident and Emergency services. In terms of medical referrals, the difficulty is that, in order to develop further, *Voluntary Hospital* must 'pass on' less complex procedures to other hospitals. This is essential in order to create spare capacity for more profitable and prestigious interventions. As it has already reached its organisational limits, the hospital must therefore attempt to influence medical referrals.

Because of the autonomy of the medical profession, this issue must be approached with caution, and this helps to explain why the CEO has so far concentrated his energies on the political sphere, seeking to raise these issues in national fora. By translating the specific organisational goals of *Voluntary Hospital* into policy proposals with wider relevance, he has been able to construct alliances with other hospitals and to place issues on the policy-making agenda:

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[78] CEO of *Voluntary Hospital*, Interview M-3.

I'm Chairman of the xxx Association, where we come together and talk about issues. ... [Researcher: And would they be mainly focused on that sort of strategic level?] Oh yeah. [Researcher: What kinds of things are on the agenda?] For example, on the Academic Teaching Hospitals in Dublin we're talking about A&E services, national services, the influx of stuff from the country, where they get two bites of the cherry down the local hospital, shove it up to Dublin and we've developed hospitals outside Dublin. We're saying "this stuff shouldn't come up".[79]

In terms of *emergency treatment*, the main difficulty facing *Voluntary Hospital* is described in the following extract:

Now the difficulty with us is the more we do, the more we become efficient, what happens is there's a self-destruct button, because we don't have a cut-off point. So now by giving open access... Well, I'm saying from other hospitals I've worked in, when we've got the A&E working right, more and more patients came.[80]

This is another example of the contradictions that beset management strategies: the aim of improving the functioning of the Accident and Emergency Department conflicts with the aim of achieving greater control over patient flows. An efficient Accident and Emergency service leads to an influx of patients from all over the city. As a result, the ability of the hospital to focus on high-value-added procedures is curtailed. The CEO has incorporated this consideration into his strategic approach by focusing on the notion of 'catchment areas'. Once again, this represents an attempt to influence medical decision-making. Although the hospital is obliged to provide emergency care, the CEO is concerned that this role should be linked as closely as possible with a definable catchment area and integrated with a strategic approach to admissions. This leads him to emphasise the 'core business' of the hospital:

What I'm saying is, let's look at our catchment and look at the population. We're very good at cancer: breast cancer, rectal, prostate. So OK, we will take referrals from other hospitals, as long as they'll take it to a certain level. So what we're

[79] CEO of *Voluntary Hospital*, Interview M-3.
[80] CEO of *Voluntary Hospital*, Interview M-3.

saying is we should share our waiting lists with the GPs. No patient refers himself directly to this hospital. I'm trying to explain that to everyone. They refer. [Researcher: So that's the link to the catchment?] And then we've all the hospitals in that catchment linked in to us. ... there's a benchmarking called casemix index, and our casemix index is 1.28. I'm saying that ANYTHING from outside Dublin under 1, it should not be here. Because ALL the other hospitals are up to that level.[81]

It is interesting to note that the external environment was relatively conducive to the pursuit of these strategic goals, for a number of reasons. The absence of a strong 'market-driven' system facilitated contacts between hospitals and the incremental nature of the health reforms enabled the most influential actors within the system to exercise a disproportionate influence on the policy-making agenda. Moreover, the size and importance of *Voluntary Hospital* enabled it to pursue organisational goals within the political sphere as the obstacles to the development of this hospital could be presented as 'systemic problems'. It is also apparent that the CEO's emphasis on the importance of planning in relation to 'clinical autonomy' dovetails with policy-makers concerns about the spending implications of doctors' decisions about patient care.

However, the external context also included a number of obstacles, as the competitive orientation of the CEO was constrained by the consensual, political nature of decision-making within the Irish health service:

Now if I was suddenly to apply the DRG system, every Dublin Academic Teaching hospital would wipe the floor with the other hospitals. So what one has to do is gradually bring in that system, and then as you say... In my business, now, I would love tomorrow to be paid... We have a cystic fibrosis programme and liver programme. The DRG weighting for that is HUGE. What do they do? They bloody well halve the relative value! Because if they'd left it at the high level, I'd have got twice as much money![82]

[81] CEO of *Voluntary Hospital*, Interview M-3.
[82] CEO of Voluntary Hospital, Interview M-3.

This provides further evidence of the distinctively *political* constraints on local management strategies, as in Southern Italy. The application of the DRG system of casemix funding is 'budget-neutral' in Ireland due to central spending constraints, which implies that the gains of 'efficient' hospitals are inevitably at the expense of other hospitals. As I suggested in Chapter Two, this cuts against the political logic of the main political parties, as both Fianna Fáil and Fine Gael rely on a populist approach in which re-election depends primarily on the ability of politicians to provide gains for their constituents, as a union official observes:

> *If I am a TD (Member of Parliament), the last thing I would want is a hospital to close. The Lourdes hospital in Drogheda – I live in Drogheda – which is just one, employs one thousand people. Now if we had the IDA announcing that a multinational is going to reside in Drogheda with a thousand... Be the Lord Harry! You would have the* Taoiseach *(Prime Minister) and the Minister and everyone up to cut the ribbon! It's constant, it's permanent, pensionable employment. It absorbs 30 million a year into the economy in the area. ... Remember that, and it comes back into that. It puts things into perspective: "I want my hospital and you won't close it". So in fairness to the health service managers they have got to work within that.*[83]

Unsurprisingly, the CEO of *Voluntary Hospital* is also attempting to increase hospital capacity as a way of furthering his organisation's strategic goals. In contrast to the limited autonomy of the acute hospitals in Italy, the Voluntary Hospitals in Ireland have greater room for 'manoeuvre' within the market for health care. As well as altering the distribution of resources within the hospital, they can exploit synergies between the public and private systems, as I will show. Thus, health service rationalisation in Ireland has given greater impetus to the competitive restructuring of the large acute hospitals, even in the absence of a market-based system:

> *... one of the things when I first came here, the Board was saying they were going to have a £3m development. I said "For Christ's sake, get real! Let's look at the whole thing again, go back to basics": strategic look at what's coming in health care ten*

[83] Liam Doran, Interview U-11.

years down the road, as you say, what's happening worldwide, Europe, and let's look at it rationally. ... that's where I see the role of the CEO and the Board, is to be moving quicker than the outside world, so we can ensure that the inside world is moving as quick and is not being left behind. Because if I'm just sitting here, I could sit here very comfortably. But we'd be out of date within a year.[84]

Alongside this development, the CEO was determined to exploit the possibilities offered by the presence of the private hospital on the same site as the public hospital. This is an extremely interesting issue, as it is situated in the 'grey area' between the official regulations created by legislation and the aggressive pursuit of organisational goals by individual actors within the system:

Now in the new development I'm suggesting we should build on two extra Theatres and two extra Intensive Care beds for private patients, because I can provide that service much cheaper, because they'll never get the expertise in there (into the private hospital). So why not add it on to the public hospital and say that they're dedicated, using economies of scale for both systems? [So the flexibility is there in the legislation to allow you to do it?] Yeah. Well, let's say// [//Can you have a single cost centre which is funded by both systems?] Well, we can (unsure), we can do that. But I have to be honest with you, the legislation doesn't... I'm not allowed to charge private patients a technical fee. ... I'm building ten Theatres already, why don't I build another two, and get the private hospital to pay me back over five, ten, fifteen years? [So it will be called 'private' on the books?] So it means that they can charge. I mean legally, we're getting around it by saying they're outsourcing me to do this. What I'd say is: "Yep, and I'll charge you at the going rates".[85]

The CEO of *Voluntary Hospital* views the unions as a significant internal obstacle to the achievement of his strategic goals, as they obstruct the pursuit of greater efficiency and flexibility in the deployment of labour within the hospital. There is therefore a sense in this hospital that nurses' aspirations must not interfere with the strategic development of the hospital. As in Italy, the emergence of 'new' forms of management within the large

[84] CEO of Voluntary Hospital, Interview M-3.

acute hospitals in Ireland is an important development. On the basis of the interview material, it is apparent that a number of managers have distanced themselves from the previous 'ethos' of hospital management on the basis of ambitious and long-term plans for hospital development in the future. Naturally, the implementation of a strategic plan over a longer timescale implies a high level of managerial autonomy, and this explains the critical attitude of managers in both *Azienda* and *Voluntary Hospital* in relation to all forms of union organisation and representation. Nursing staff, in particular, are expected simply to implement managerial decisions, and this is typically justified by reference to the needs or demands of patients.

Second Case Study Hospital - *Azienda*

The second case study hospital that I will examine is a large acute hospital on the outskirts of Naples (*Azienda*) which mainly carries out elective interventions and diagnostic procedures for patients suffering from respiratory, urinary and gastrointestinal complaints as well as cardiovascular disease. It does not have an Accident and Emergency department, although emergency cases are often transferred there from other hospitals. In late 1994, following the health reforms, a new *Direttore Generale* (General Manager) was appointed from outside the health service. His lack of personal 'debts' within the health service and his experience of management in the private sector are important factors in explaining his relative autonomy from the political sphere, as is the fact that during this period managerial appointments were based upon a relatively 'neutral' set of criteria. This hospital therefore provides an excellent opportunity to compare the impact of the Irish and Italian health reforms at hospital level.

The potential of *Azienda* to become a specialised centre for the diagnosis and treatment of serious illness – one which could attract patients from throughout Southern Italy – was immediately clear to the General Manager. However, he was also conscious of the weaknesses in the current position of this hospital and its vulnerability to competition from other institutions. Were a rapid growth in private health care to occur as a result of the new health legislation, the interventions carried out in *Azienda* would be a prime

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[85] CEO of Voluntary Hospital, Interview M-3.

target for private providers, due to their high casemix weighting (see Chapter Two). Thus, the subjective environment of the *Direttore Generale* was shaped primarily by the content of the legislation of 1992-3 and its provisions regarding 'marketisation':

> *The citizen who encounters poor facilities for heart surgery in Reggio Calabria, rather than deciding to go directly to Milan, could come to Naples. And if people in Reggio Calabria get organised, they can eliminate this emigration from the less-equipped areas towards those which have better services - this is the aim of the State in relation to the health service.*[86]

Thus, the most important element of the external environment of this manager was the possibility of competition from other hospitals, which would have the effect of reducing the income of the hospital due to the operation of the casemix funding mechanism and the freedom of patients to choose between alternative health care providers. As a consequence, the primary strategic aim of the *Direttore Generale* was to develop a coherent business plan based upon the treatment of a closely-related set of pathologies, as in the case of *Voluntary Hospital*. This is reminiscent of the emphasis on 'core business' found in managerial texts:

> *[Researcher: In your opinion, what is the aim of the* Direttore Generale*?] To make the hospital take off. I believe his aim is to develop the Thoracic divisions... We have a Paediatric Cardiology ward, a Paediatric Heart Surgery ward, we have a whole range of supports to care for the pregnant woman with heart problems.*[87]

The most important internal factor which limited this manager's ability to achieve his objectives was the physical, professional and even moral degeneration of the hospital. This posed a threat to its competitiveness, as it discouraged patients from placing their trust in the hospital and its employees. For this reason, overcoming this 'degeneration' became an important element of management strategy in this hospital. Firstly, the *Direttore Generale* set about upgrading the appearance of the hospital, using regional funding earmarked for the improvement of the hospital infrastructure. Work began

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[86] General Manager of *Azienda*, Interview M-1.
[87] Female Unit Nursing Officer in *Azienda*, Interview 2-1.

immediately on the façade and surrounding gardens; internal corridors were retiled and the entrance hall was redecorated. The effect was reminiscent of a luxury hotel, complete with sliding doors, potted plants and receptionists. This was the first time that a public hospital in Naples matched the attractive appearance of the private health clinics, with large expanses of polished marble and manicured lawns.

Secondly, in terms of professional standards, the *Direttore Generale* adopted a two-pronged strategy, tightening up on work discipline and adopting a proactive approach to staff recruitment. In relation to the first issue – which attracted great attention in the Neapolitan health service – the main innovation was to reduce absenteeism and to carry out 'sweeps' of the hospital to check whether all staff members were present and (at night) awake. The *Direttore Generale* also sought to improve the capacities of hospital employees, providing courses in the use of computers, for example, and supporting the participation of nurse managers and medical staff at conferences. He sought to retain high-profile Consultants and to attract other respected clinicians by capitalising on the legislative changes introduced by the Minister for Health, which permit Consultants to carry out private interventions within the public hospitals.

As I mentioned in Chapter Two, the health reforms of 1992-1993 also allow the General Manager to appoint Senior Consultants (*Primari*) directly, and the *Direttore Generale* was therefore able to use these appointments as a way of pursuing his strategic goals. In addition, he went to great lengths to provide surgeons with high-quality facilities, realising that this would enhance their loyalty to the hospital and hoping that their reputation would attract more patients.

Thirdly, the *Direttore Generale* aimed to abolish the corruption and inequities present within the hospital environment, adopting a hard-nosed approach to suppliers and facing up to senior medical staff who were not committed to his goals. The most dramatic example of the autonomy and determination of this manager was his decision to sack a Senior Consultant accused of corruption – one of the few cases in which a *Primario* has been dismissed from a public hospital in the South of Italy. He also introduced spot checks at the hospital gates to detect petty theft by staff members.

The main external factor which facilitated the *Direttore Generale* in these areas was the high level of autonomy which the reforms of 1992-93 granted to the large, acute hospitals. Within the hospital, the existence of a relatively strict management tradition prior to 1978 also provided an important precedent[88]. The *Direttore* was also assisted by the ambiguities inherent in the new legislation, which meant that his internal opponents were often unable to appeal his decisions, even where they suspected that he had exceeded his jurisdiction.

Moreover, the corruption scandals of the early 1990s reduced the hold of clientelism at regional level, increasing hospital managers' room for manoeuvre. Regional power-brokers needed 'modernisers' such as the *Direttore Generale* in order to implement 'reforms'. During the mid-1990s the election of a Centre-Left coalition to the regional administration reinforced this process, although the changes witnessed in *Azienda* in these years stand in marked contrast to the situation in most other hospitals in Southern Italy. Another important factor underlying the independence of the *Direttore Generale* of *Azienda* was the weakness of the union movement. Because of their leaders' involvement in corruption scandals, the main unions suffered a considerable loss of legitimacy during the early 1990s (see Chapter Six).

As a result of his competitive focus, the *Direttore Generale* was particularly sensitive to the importance of avoiding negative media coverage. To this end, he appointed a journalist to manage the hospital's contacts with the media and to write press releases, intervening immediately whenever there was evidence of medical error, poor service or conflicts between staff and members of the public. However, it is interesting to note how this aspect of the General Manager's strategy came increasingly into conflict with his determination to sideline the unions and to maintain a unilateral approach to decision-making. This was because the unions, despite their organisational weaknesses, understood that they could bring pressure to bear on management by contacting the media and releasing information about management decisions.

[88] Although the system of the *casse mutue* was generally characterised by clientelism and political influence, there were also exceptions to this.

As well as developing a focused approach to the competitiveness of the hospital, the Manager of *Azienda* also sought to enhance efficiency levels. This led to an improved integration between wards and services, rapidly reducing the average length of patient stay. Whereas previously, diagnostic procedures had been carried out at a leisurely pace, the *Direttore Generale* pushed for an acceleration of throughput in all areas, primarily by placing medical staff in a position to work more effectively. Naturally, improvements in the efficiency of the support services tended to stimulate improvements in the management of the wards, as staff members sought to keep up with the process of diagnosis and treatment:

> *Before the 502 [legislative decree], it took a month to get a* stratigrafia *[a type of X-ray], nobody took account of the time. You made a request, but if you didn't keep calling you wouldn't get it. And it took time. ... If there was a patient in* Pneumologia*, and you requested a chest X-ray, it was done relatively quickly, but it was a different story if you asked for something more specific, because the X-ray Department would respond: "It's not as if it's an emergency, you'll have to wait".*[89]

Secondly, by centralising a range of services – such as the operating theatres, for example – the duplication of services and problems of access were mitigated. The reorganisation of the hospital resulted in a 'departmentalised' system with a more rational grouping of wards and with a more functional management structure. Nevertheless, it is worth noting that the *Direttore Generale*'s need to retain influential Consultants, as mentioned earlier, came into conflict with the demands of rational organisation, as certain wards and services were able to exercise a veto in relation to the restructuring.

It is worth noting that it was not necessary for the *Direttore Generale* to impose specific production targets at ward level in order to reduce the average length of patient stays. Simply by reasserting managerial authority and work discipline, by improving the coordination of services and providing Senior Consultants with incentives, a rapid increase in patient throughput was achieved. Because the performance incentives of

[89] Male Ward Sister (43 years of age) in *Azienda*, Interview 2-15.

senior medical staff were dependent on their productivity, most Consultants embraced the 'efficiency drive', and other members of the patient care team followed suit.

During the mid to late 1990s, changes in the political context gradually reduced the scope for dynamic management strategies in the Neapolitan health service, and the dependence of hospital managers upon the political system was, to a certain extent, restored. As I mentioned earlier, the corruption scandals, the collapse of the DC political party and economic crisis created the conditions during the early 1990s for more autonomous local management. However, there seems to have been a reassertion of a clientelistic logic during the late 1990s due to the heightening of electoral competition in the Campania Region and due to the *Ribaltone*, a manoeuvre which secured the survival of the regional administration by bringing ex-Christian Democrats into the governing coalition in a transversal alignment with the Centre-Left. This helps to explain why the positive achievements of *Azienda* were not emulated in other hospitals in Southern Italy; on the contrary, the *Direttore Generale* found himself increasingly isolated at regional level.

The post-war political history of the *Mezzogiorno* indicates that periods of overt political influence and corruption have always been interspersed with brief interludes of 'renewal' during which a veneer of change is presented. For example, Antonio Oddati (1993) recounts his experience as administrator of the Local Health Unit in Eboli, in the South of Italy, during 1991. The Socialist Party, which at the time controlled the area around Salerno, was under pressure to 'clean up' its operation, and this facilitated the appointment of an ex-Communist Party activist to the LHU in Eboli. But as Oddati gradually improved the functioning of local services, he came into conflict with vested interests and was removed from his position after little more than a year:

> *The LHU, the Local Authority, the public institutions and the private companies who deal with them, are considered locations to be occupied, over which power may be exercised. In the battle between the different forces, it is possible to lose power or to win it back, but everything unfolds as if in a game, according to unwritten rules which are those of 'politics'.* (Oddati, 1993: 38)

Thus, a contradiction has opened up between the political strategy adopted by the Italian state in the early 1990s and the electoral strategy pursued by the dominant political parties. It is unlikely that the central state will continue to subsidise clientelistic electoral machines to the same extent as in the past, as this clashes with the fundamental strategy of the ruling elite, namely to ensure participation in European Monetary Union and to carry out a far-reaching restructuring of the state in order to meet the competitive challenge that this represents. This reveals further complexities in relation to welfare reform in the 'particularistic-peripheral' European countries, as the weakness of the central state in these countries and its vulnerability to organised interest groups interferes with the straightforward implementation of certain policy models. To the extent that the unions are committed to health service rationalisation, they may find themselves in the paradoxical situation of pushing reluctant managers to pursue greater efficiency at local level.

One of the factors that increasingly constrained the ability of the management of *Azienda* to pursue its strategic aims was the increased self-confidence of the unions. Having been excluded almost completely from decision-making for two or three years, local union representatives began to assert themselves towards the end of the 1990s. They were assisted by the growing frustration of union members, who had initially welcomed the even-handed nature of hospital management and the commitment to improving the quality of care, but subsequently found workloads difficult to sustain.

Thus, the undeniable achievements of the *Direttore Generale* in the first Italian case study hospital were dependent upon a series of contingent circumstances, which came together during the mid-1990s but grew more and more problematic towards the end of the decade. The improvements in the physical structure of the hospital were attributable to his technical abilities and strategic approach and the availability of government funding for hospital improvements. The enforcement of work discipline was facilitated by the moral and financial bankruptcy of the previous system, which was characterised by high levels of absenteeism and petty theft. Rapid improvements in efficiency in this hospital were achieved as a result of the co-ordination of work tasks, incentives provided to medical staff and a massive increase in the intensity of the labour process.

Not only did the manager of this hospital achieve improvements in the functioning of the hospital, he also embodied a new form of management more in tune with the reforms. The main contours of this approach are, as I have shown, its strategic nature, its autonomy from interest groups within the hospital, its emphasise on the competitive pursuit of new customers and the enforcement of managerial authority within the workplace. As I will show in the next chapter, many nurses welcomed these developments, and this was also true of a number of union representatives[90]. However, questions may be raised about the sustainability of these changes. In the end, the *Direttore Generale* was forced to accept that managerial decision-making in the health service involves a much greater degree of negotiation and compromise with unions, politicians and powerful groups of employees than he had previously entertained. The departure of this manager after his mandate expired confirms the fragility of the changes that were obtained within *Azienda* and the risks associated with a cavalier and unilateral approach.

Third Case Study Hospital - *Presidio*

In this section, I will discuss the nature of management strategies in the second category of public hospitals in Italy, those administered directly by the *Aziende sanitarie locali* (Local Health Units). As I mentioned in Chapter Two, directly-managed hospitals account for roughly 80 per cent of public beds in Italy, despite the high profile of the *Aziende Ospedaliere*. The third case study hospital is a medium-sized Directly-Managed Unit, or *Presidio ospedaliero* in the centre of Naples (I will therefore refer to this hospital as *Presidio*). It forms part of the massive *ASL Napoli 1*, the largest LHU in Italy and probably one of the largest in Europe. The principal task of this hospital is to provide Accident and Emergency services to a large, deprived area of Naples, and nearly all patients – from trauma cases to cardiac arrests and women in labour – enter the hospital via the Accident and Emergency Department. For this reason, it has very little control over admissions and fights a losing battle to maintain standards of care in the face of very high turnover rates, as a Ward Sister observes:

[90] As this is a highly complex issue, I will postpone all discussion until Chapter Five.

> *I cannot plan today what I will do tomorrow in the ward. In the morning I take stock of the situation and organise the service in concrete terms around the problems of the day.*[91]

Whereas the health reforms were central to the subjective environment of the General Manager of *Azienda*, the situation in *Presidio* couldn't be more different:

> *According to the regional plan, this hospital should become a* Dipartimento di Emergenza di Secondo Livello, *with its own 100% autonomous structure, even though we don't have all of the necessary wards. ... We are neither experiencing nor participating in the process of* aziendalizzazione.[92]

The main feature of the subjective environment of local management of *Presidio* is undoubtedly the uncertainty surrounding the future of the hospital. Although it has the potential to become a specialised Accident and Emergency hospital with full autonomy, it would be misleading to suggest that local managers are actively pursuing this goal. In fact, because of their lack of autonomy, the high rate of managerial turnover, the uncertainty of the institutional environment and their inability to plan emergency care, there are limits to the extent to which local managers may even be considered 'strategic actors'. Their actions are primarily concerned with crisis management and the attainment of modest improvements. For example, the main achievement of the *Direzione Sanitaria* during the course of 1997 was to petition central management for private security guards to control access to the hospital – prior to this, access was unobstructed both day and night. This amelioration in the situation at local level required many months of lobbying on the part of managers, unions and professional representatives. Despite this improvement, the main problems confronting *Presidio* are its decrepit state, the shortage of staff, the poor organisation of the wards, the risks faced by employees and the lack of equipment and facilities. If we focus on the issue of the shortage of staff, the impotence of the *Direttore Sanitario*, the manager in charge of this hospital, is readily apparent:

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[91] Male Ward Sister of Orthopaedic and Trauma Ward (43 years of age) in *Presidio*, Interview 3-11.

[92] Male Staff Nurse (42 years of age) and union representative in *Presidio*, Interview 3-17. *Aziendalizzazione* is the term used in Italy to refer to the health reforms of 1992-93, and not just to their 'managerialist' dimension.

The management of the Local Health Unit states continuously that it has an overall staff surplus – that may be true, they have done their calculations – but at least as far as this hospital is concerned, we have the lowest number of staff in relation to beds of any hospital in the city. Nevertheless, we are still told that we "fall within the parameters", that we are "above the parameters allowed for".[93]

Thus, the rigidity of the external constraints do not facilitate strategic decision-making at *Presidio*. The rapid turnover in managerial staff gives the impression that managers are simply 'doing their time' whilst awaiting a more attractive opportunity. Rather than finding a *strategic* outlook, instead we encounter a form of pragmatism and a concern to resolve day-to-day problems by means of consensual solutions.

In order to evaluate the impact of rationalisation on this hospital, it is necessary to explore the outlook of the managers of the Local Health Unit as well as local managers. The *ASL Napoli 1* was created in 1994, and is responsible for ten acute hospitals, including *Presidio*, as well as numerous local health services and community care throughout Naples. The outlook of managers at the *ASL* is influenced primarily by the need to restructure the Neapolitan health service in order to cut spending levels:

We have a budget of £840 million. ... We have roughly 15,000 employees. Of these £840m, £600m are 'structural': £440m for wages and roughly £160m for management and overhead costs. We apparently have £160m available, but that is required for compulsory purchases from the private sector. ... Just think, between public and private, we have a surface area of 1,400,000 square metres dedicated to patient care. Within the private sector here in Naples, we have 140 service providers under contract, one worse than the other.[94]

The main strategic aim of the *ASL* is to cut spending levels, as the process of rationalisation clashes with the inefficiency of the Neapolitan hospitals. Many of the hospitals managed by the LHU are small and run-down, characterised by serious

[93] Health Director of Presidio, Interview M-6.

structural problems. This illustrates the difficulties that managers in Southern Italy face in implementing the rationalisation of the health service. Organisational change, managerialism and marketisation have increased the pressure for structural reforms. However, the obstacles to restructuring are not merely managerial. From the perspective of the *ASL*, *Presidio* is inefficient by its very nature, despite the fact that local managers and union representatives complain about staff shortages. Even though bed occupancy rates are well above unity in some wards (implying that, on average, more than one patient is treated each day *in each bed*[95]) and stretcher beds are common, the hospital does not benefit from its high activity rates because of its small size and because Accident and Emergency care is penalised by the DRG system. The main strategic aim of the *ASL* management is therefore to close *Presidio* – and a number of small metropolitan hospitals – and to build a new hospital:

> *We intend to close three hospitals ... in order to build a new one to the West of the city. This will decongest the city centre, which means that we are in line with the Local Authority's plans: we empty the historic city centre of services and fill it up with tourism and monuments, upgrading the periphery.*[96]

This explains the uncertainty expressed by local managers, who appeared unable or unwilling to formulate any strategic organisational goals. Because the Local Health Unit has the intention of restructuring the network of health care providers in a rather dramatic fashion, there is little incentive for strategic management at local level. In the intervening period, conditions in the hospitals concerned will remain precarious, as the LHU is unlikely to provide additional resources for patient care in the knowledge that the hospital will be relocated in the future. As far as the timescale for the new development is concerned, some managers hypothesised a delay of just five years. Although five years have elapsed since this interview, the new structure is no nearer

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[94] Manager of ASL Napoli 1, Interview M-5. All figures have been converted to Irish pounds, which may be converted to Euro by multiplying by approximately 0.8.

[95] It often happens that a patient is admitted by the A&E Department, moved temporarily to a ward and allowed to leave later in the same day. This is common in the Orthopaedic ward, for example, where the victims of minor accidents may decide to return home after diagnostic tests have been carried out and their injuries have been bandaged.

[96] Manager of ASL Napoli 1, Interview M-5.

completion than it was in 1997, and working conditions at *Presidio* continue to deteriorate[97].

The most important external constraint on the ability of the *ASL* to implement its strategic goals in relation to *Presidio* is its dependence on the regional government, which now has responsibility for the strategic development of regional health services. LHU managers criticise the regional health plan for its failure to rationalise the hospital network due to political opposition to hospital closures. This calls attention once again to the role of clientelism in obstructing the implementation of health reforms in the *Mezzogiorno*. This issue is important, as it forms part of the complicated constellation of political mechanisms within which the public administration operates in Italy. Hospital managers are politically important because they occupy a critical position in the local economy. A large hospital provides jobs for hundreds (if not thousands) of people, consumes vast quantities of materials and intervenes in the lives of thousands of patients. Thus, the public hospitals provide a means of achieving social consensus as well as providing a launch pad for local politicians. As I suggested earlier, clientelism is just one of the strategies used by politicians in the South of Italy, but it has traditionally been the most significant and the most resilient to change.

As I argued earlier, the creation of the national health service in 1978 was followed by the creation of a differentiated system of political control. As well as enabling politicians to secure re-election, clientelistic relationships also provided hospital managers with a means of increasing their own status and wealth:

> *... this hospital has been the launch pad for Ministers, Mayors – two Mayors came out of here. Cirino Pomicino worked in here, other Ministers. ... Basically, they constructed a political base. Its no accident that I'm the Secretary, some day I could gain an advantage in an electoral contest – even inside the Party – by virtue of being Party Secretary in a hospital like this.*[98]

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[97] A partial renovation was carried out in the intervening period, funded under the 'ex-articolo 20' which provides additional resources for the modernisation of hospitals in Southern Italy.

[98] Male political activist from the Communist Refoundation Party in *Emergency Block* (42 years of age), Interview 4-2.

Returning to the situation of the *ASL Napoli 1*, it is obvious that this Local Health Unit is central to the electoral calculations of the entire Neapolitan political class, and this imposes an organisational and administrative logic upon it which is at odds with the core principles of health service rationalisation. As a result, the managers of the *ASL* have a limited ability to intervene strategically in the health service:

> *If you like, you can return in a week's time and I will show you our plans. They are basically the things that I have been telling you about: cutting back on spending, redefining the structures – but nobody will let us do anything. Neither the political context, nor the interests of the employees, nor the unions will allow us to do anything.*[99]

Summary

In this chapter I have highlighted a number of potential obstacles to the implementation of health service rationalisation in Ireland and Southern Italy. It is clear that the nature of hospital management is highly sensitive to structural features of the health service. For example, large acute hospitals can carve out a sphere of autonomy within which they can pursue strategic goals. However, even where contingent factors come together to produce a manager who fits the managerialist 'identikit', the significance of this innovation is curtailed by its limitation to a very small number of actors within the health service and by the presence of contrasting imperatives emanating above all from within the political sphere.

Thus, the political context of public sector management in both countries places constraints on managerial decision-making. The health service plays a key role in the electoral strategies of all of the political parties, and clientelistic pressures (particularly in Italy) have already demonstrated their capacity to undermine the autonomy of hospital managers. One of the mechanisms underlying this outcome is the appointment of individuals distinguished more by their political loyalties than their technical or organisational skills. Although Irish managers are also subject to substantial political

[99] Manager of ASL Napoli 1, Interview M-5.

pressures, these assume a more impersonal form and do not involve a clientelistic strategy geared towards exploiting public resources for electoral purposes.

In conclusion, it is important to recognise the dynamism of the managers of the two large, semi-autonomous hospitals discussed in this chapter. By virtue of their strategic approach to the achievement of organisational goals, both the *Direttore Generale* of *Azienda* and the CEO of *Voluntary Hospital* were able to access funds and to upgrade their hospitals. Moreover, by applying 'professional' management approaches, they were able to redefine their 'core business', set out a competitive strategy for the future and obtain information on the efficiency of individual wards. This approach to management offers some benefits to patients by implementing a better co-ordination of work roles within the hospital, by supporting professional training and by providing for the devolution of decision-making power to ward level. This function of co-ordination within the labour process is of direct interest to nurses, and this helps to explain why many interviewees had a favourable overall opinion of the *Direttore Generale*.

Not only have these managers achieved improvements in the functioning and efficiency of their hospitals, they have also established a precedent for a new *approach* to management. Thus, it is possible, at least in principle, for organisational change and marketisation to generate changes in the orientations, practices and self-understandings of hospital managers. It is therefore timely to examine the impact of new forms of hospital management on the nursing labour process and on structures of union representation at local level. In the next chapter, I will take up the first of these issues by providing a detailed analysis of nurses' work grievances in the case study hospitals, and in Chapter Six I will link these with union responses to rationalisation.

V THE WORK GRIEVANCES OF HOSPITAL NURSES IN IRELAND AND SOUTHERN ITALY

Introduction

In Chapter 2 I provided an overview of the changes that have taken place in health policy in Ireland and Italy over the last two decades, and in Chapter Four I showed how these changes have been implemented by health service administrators and hospital managers. In this chapter I will provide a detailed analysis of the opinions of hospital nurses in relation to their work, concentrating on the issues that they identify as problematic within their workplace. This will set the stage for the final chapter, in which I will examine the dynamics of workplace union representation in relation to the aspirations of union members and the leadership provided by national and regional officials.

I will use the term 'grievance' to refer to issues that nurses themselves identify as problematic or detrimental to their well-being. I will argue that grievances express relatively enduring contradictions in the situation of a group of workers and are mediated by social, cultural, political and institutional factors. My aim is therefore to show how grievances emerge from the nature of nursing work, on the one hand, and social interactions between nurses, on the other. The complex processes involved in the articulation of workers' grievances are of great theoretical interest, as they mediate between the structural characteristics of the 'labour process' (Braverman, 1974; Brighton Group, 1977; Burawoy, 1979, 1985; Edwards, 1979, 1986; Jermier et al., 1994; Knights et al., 1985; Knights & Willmott, 1986, 1990; Smith et al., 1991; Smith & Thompson, 1997; Wood, 1982), on the one hand, and trade union organisation, renewal and struggle, on the other (Cohen & Fosh, 1988; Darlington, 1993, 1994, 1995, 1998; Fairbrother, 1989a, 1989b, 1990a, 1990b, 1994a, 1994b, 1996; Fosh, 1981, 1995; Fosh & Cohen, 1990; Fosh & Heery, 1990; Gall, 1998; Hyman, 1979, 1986; Spencer, 1989; Terry, 1993). Given the potential benefits of linking these two areas of analysis, it is rather surprising that the concept of 'grievances' has not received greater attention. Arguably, middle-range theory explaining the determinants of grievances can bridge the gap between social structures and individual agency and thus help to resolve some of

the difficulties expressed by contemporary labour process theorists and industrial relations analysts.

Methodological Considerations

The empirical identification of grievances presents considerable methodological challenges, due above all to their subjective nature. Grievances cannot simply be 'read off' from the structural characteristics of the workplace or from the contractual conditions of a group of employees. Moreover, the identification of grievances is a collective and social phenomenon, and this tends to undermine individualistic analyses. Neale (1983) emphasises this point in his account of the grievances which fuelled industrial action by health workers in one British hospital in 1982. He describes how the 'outside porters' – whose job it was to bring patients to and from the Operating Theatres – were concerned to obtain a room in which they could wait for their next job without having to endure the humiliation of other workers' comments about their 'inactivity'. Cleaning staff were incensed by the fact that clerical staff had a newly-decorated suite of rooms with mirrors and dressers, whereas their own rest-room did not have enough chairs to sit on during the tea break. Similarly, in Naples, the failure of managers to provide decent uniforms and changing-rooms is a source of frustration and anger amongst nurses. Far from being 'frivolous', these issues are extremely important to those concerned, both because of their impact on the individual's day-to-day experience of work and because they often come to symbolise disparities of power and status within the workplace.

The subjective and social character of work grievances implies that workers do not have a fixed set of issues which they can simply recount to the researcher. In contrast, grievances are actively constructed during the interview process and during discussions between work colleagues. This implies that the nature of the interview has a strong influence on the issues reported. Mishler (1986) argues that informants and interviewers should be seen as 'co-constructing' the meaning of the interview, the latter by asking certain questions, by their pauses, insistence, interruptions and choice of words and the former by providing distinctive interpretations and selective information. Similarly, Kvale (1988) suggests that interview data are not 'collected' but 'co-authored'. For this

reason, it is important to carry out interviews with a range of different actors, including ordinary workers themselves, both individually and in groups, and to supplement these interviews with careful observation of social interactions within the workplace. As Erickson (1977) suggests, social meaning is constituted primarily by what social actors *do* in the course of their everyday lives, and these meanings are best uncovered by observing people and inquiring about the reasons for specific behaviours.

In the course of the current research project, I conducted focus-groups as well as individual interviews and spent considerable periods of time simply 'hanging around' in the wards and listening to conversations between nurses. The pretext for this non-participant observation was the circulation of a short questionnaire about working conditions (see Appendix A). Similarly, changing-rooms, canteens and coffee-rooms provided ideal locations for fieldwork. Clearly, gaining access to these locations is conditional upon the cultivation of personal relationships with individual nurses, which carries both benefits and risks as far as the research process is concerned. On the one hand, the greater continuity which this affords in terms of data collection is a great advantage, as are the participation and trust which it engenders. Nevertheless, it is important to develop a strong element of reflexivity and self-questioning in order to counteract tendencies towards 'incorporation' or 'going native'. Reflexivity is also an essential counterweight to the theoretical limitations and rigidities induced by adherence to a specific research programme.

As nurses congregate before, during and after work, problems are discussed and grievances are aired, and it is often in the course of these interactions that work grievances come to be identified, as workers realise that their own individual difficulties are shared by a wider group of people. In many cases, nurses do not come to identify *their own* difficulties until the latter have obtained inter-subjective expression. For example, nurses may not identify 'lack of autonomy' as a grievance until they hear their colleagues criticising the attitudes of managers and medical staff. Nurses may also have grievances which are confined to their own situation. Although these 'individual grievances' are sometimes of relevance to wider groups (e.g. where a nurse transferred from one ward to another without prior notice, other workers may perceive this as threatening their own situation), grievances that are linked with the specific work

situation of a single nurse are also encountered. Although my main focus in this chapter is on collective grievances, I will also discuss issues which fall into this latter category[100].

The integration of quantitative and qualitative data is a considerable strength of this research project, as interviews and observation facilitated 'thick description', whilst the questionnaire survey yielded baseline data on the overall population of nurses. This multi-method approach reflects a desire to overcome the rather artificial distinction between quantitative and qualitative approaches to 'doing sociological research'. The combination of quantitative and qualitative methods offers a number of advantages, as quantitative data can help to identify deviant cases, supply background data and avoid both 'elite bias' and the 'holistic fallacy' (where monolithic judgments are made on the basis of a restricted pool of data) (Sieber, 1973). Moreover, the estimation of standardised scores and regression models can provide insights into differences between sub-populations of nurses and shed light on the relative importance of a range of different factors on work grievances.

Conversely, qualitative data facilitates conceptual development, the detection of complexities and contradictions and the interpretation of research findings (Sieber, 1973). My aim is therefore to exploit both types of data, using qualitative data to provide a sense of 'local groundedness' and quantitative data to evaluate the representativeness of the interview volunteers and to contextualise their responses. Extracts that exemplify a particular observation or comment will be used to provide 'thick description', to 'bring the local setting to life', in the words of the actors directly involved. However, I will also quantify the representativeness of these extracts in order to avoid foregrounding 'vivid' but perhaps misleading examples. To this end, data matrices will be used to provide the reader with a large amount of interview material in a concentrated form.

[100] But note that Cohen & Fosh (1988) argue that, due to the close relationship between individual grievances and the interests of a larger constituency of workers, "... it is impossible to say that any grievance is by its nature 'individual'. The question is whether or not it is handled in a way which brings in the shared concerns of the membership" (p. 9).

A sharp distinction between 'qualitative' and 'quantitative' data is rather inappropriate in this context, as the interview transcripts were subject to a rigorous analysis in order to identify *representative* extracts rather than merely 'vivid' or unusual ones (Kahnemann & Tversky, 1972). Finally, all three types of data – interviews, questionnaires and observation – were used in the course of the analysis, in a form of 'triangulation' (Denzin, 1978).

It is worth making a few comments about how this research was perceived within the case study hospitals and how this – together with the researcher's preferences and interests – may have shaped the process of data collection. Firstly, in three of the four hospitals, access was obtained via managerial consent, and permission to circulate within the hospital, to distribute questionnaires and to conduct interviews was provided by General Managers and Nurse Managers. In the fourth hospital, contact was made directly with ward nursing staff and a subset of wards was sampled[101] (see Appendix A for further information). Thus, from the perspective of the individual nurses, the research may initially have been associated with management. For this reason, the introductory comments on the first page of the questionnaire emphasise the independent nature of the research, the anonymity of all responses and the scientific aims behind the project (the questionnaire is reproduced in Appendix A).

Nurses who volunteered for an interview were contacted by phone at their home or in their ward in order to arrange an interview (a 'volunteer form' was included with each questionnaire). In the Italian case study hospitals, most interviews were carried out in the hospital, often in a store-room, *Medicheria* or meeting-room. Although this often led to interruptions, it facilitated extended periods of observation, frequently generated additional interview volunteers and occasionally gave rise to the formation of ad hoc 'focus groups'. Permission was sought to use a tape recorder, and in no case was this refused. Nevertheless, on a number of occasions I was asked to switch the tape recorder off so that the interviewee could provide detailed information of a rather 'compromising' nature, particularly in relation to the behaviour of union representatives or managers. In these cases, the additional information was noted carefully immediately

[101] This procedure was followed due to the large size of the hospital and the difficulty of obtaining management support for the research due to the uncertainty created at the time of the research by the death of the previous General Manager.

after the interview (see Appendix B for further details on the qualitative data collection process).

At the beginning of each interview, interviewees were provided with an assurance of anonymity and most nurses spoke freely and without reservations, as will be obvious from the extracts quoted in this chapter. Personal friendships were formed with a number of interviewees, and this enabled the researcher to return repeatedly to the hospital wards and to talk informally with nurses over an extended period of time. In particular, in Italy, the night shift provided an opportunity for in-depth conversations, due to the more relaxed pace of work. It was sometimes possible to ask a nurse from one ward to provide an introduction to colleagues in an adjacent ward; in this way 'gaps' in the coverage of the initial interview volunteers were bridged.

In Naples, one of the most important aspects of the relationship between the researcher and hospital nurses was the fact that I was not directly connected to the hospital and its local context. The perception that the researcher was a 'neutral observer' in a context characterised by high levels of mutual distrust and suspicion encouraged interviewees to 'open up' about their work situation. Rather than seeking to present a more positive picture, most informants were concerned that 'the truth should be told'. Thus, many of the interviewees exclaimed, towards the end of the interview: "I bet that nobody else has been as honest as I have!" Given the composition of the nursing workforce in Naples, where middle-aged men predominate, the most common attitude involved a 'paternal' approach, which involved helping with the research, providing an honest and open account and basically 'putting the researcher on the right track'. This attitude occasionally gave rise to difficulties, but on the whole represented a considerable advantage.

In Dublin, in contrast, a more formal relationship was established with the interview volunteers, who were mainly young women, and the research was more directly identified with the academic sphere. Many of the interviewees had studied in a university environment whilst undertaking additional qualifications or specialisations and had themselves carried out research projects during their diploma course. This led to a rather more 'formalised' interview procedure, and the interview volunteers typically

listened carefully to the researcher's questions and provided detailed and precise responses. In contrast, the Neapolitan nurses were more likely to interrupt the researcher's questions or to provide what they considered to be the most pertinent information without waiting to be asked ("What you've got to understand from the beginning is that..."). These differences between the Irish and Italian fieldwork locations were accentuated by the language difficulties encountered in Naples, which perhaps encouraged the Neapolitan nurses to be more proactive (all interviews with Italian nurses were conducted in Italian by the author, a non-native speaker).

In terms of the interviews themselves, it is worth reiterating how sensitive these were to the expectations of the participants and to the verbal and non-verbal cues provided during the course of the conversation. For example, I made use of probing questions in order to clarify possible ambiguities and to gauge the strength of the interviewees' beliefs. The following extract, from an interview with an Italian Midwife, exemplifies this approach, and shows how a probing question can lead to changes in the position expressed by the interviewee:

> *We don't want to feel superior to them (i.e. to General Nurses). We want certain roles to be respected, and we want them to be specific. ... [Researcher: If the doctor currently has higher status and more power than the nurse, do you consider yourself to be in between the two, at the level of the nurse or at the level of the doctor?] I feel superior to the nurse NOT because I want to be racist and I feel like I am above him/her. Maybe it's because, as you said, I have a different background ... and I just don't want to end up on the same rung – no. No, I want to feel like I am superior.*[102]

Although this approach to the interview can help to overcome one source of bias – the tendency to repeat 'common sense' beliefs or 'socially desirable' positions until they are actually challenged – it can also give rise to another type of bias, as multiple questions may encourage the interviewee to 'give the researcher what he or she seems to want'. A

[102] Female Midwife (45 years of age) in *Presidio*, Interview 3-6. When providing interview extracts, I will enclose all questions and comments by the interviewer within square brackets for ease of interpretation. Where a given phrase is gender-neutral in the original Italian, I will translate this using him/her or his/her. Interruptions are signalled by the use of two forward slashes at the point of overlap in speech turns // and omissions or incomplete phrases are indicated by three periods (see Appendix B).

more demanding interview style also reveals greater details about the interviewer's perspective, which can also influence the interviewee. Nevertheless, I do not believe that a more detached, 'objective' style is preferable, as the implicit preferences of the researcher are likely to continue to influence the interview and because a more forthright approach is both more honest (as it enables the interviewee to question the researcher's assumptions in turn) and more likely to produce high-quality data[103]. As far as the 'objectivity' of the *results* of the research are concerned, I have used a range of techniques that incorporate 'scepticism', helping to counteract the tendency towards 'premature closure'. These include triangulation by data source and method (Denzin, 1978), differential weighting of the reliability of informants (Maxwell, 1992), consultation of 'extreme cases' (e.g. individuals who would have the most to lose by making a specific affirmation), active pursuit of countervailing evidence (Judd et al., 1991), evaluation of rival hypotheses and use of feedback from 'insiders'.

All interview transcripts were coded using the computer programme *Atlas/ti*, on the basis of a tentative, *a priori* and hierarchical approach. The coding scheme was *tentative* because the categories were refined during the process of coding and analysis, *a priori* because an initial structure was specified on theoretical grounds and *hierarchical* because more specific concepts were grouped under more general ones (Richards & Richards, 1995; cf. Lazarsfeld & Barton, 1972). More general codes, such as 'working conditions', were used as meta-codes or 'pattern' codes, grouping together a number of the 'primary' codes used during the analysis of coded segments. The basic unit of analysis was the *phrase*; where multiple themes occurred in a single passage, overlapping code identifiers were used. In general, two to eight codes were associated with each extract, and all phrases considered relevant to the research questions were coded (the coding scheme is provided in Appendix B, and was developed on the basis of suggestions by Miles & Huberman (1994); Appendix B also contains a detailed discussion of the philosophical and methodological issues raised by the analysis of interview data). The categorisation of extracts was used to interrogate the qualitative data during the analysis phase and to construct the data matrices used in this chapter.

[103] See Mishler (1986), Rubin & Rubin (1995), Spradley (1979) and Weller and Romney (1988) on interview technique.

All four hospitals included in this research project are large acute hospitals located in urban areas, and deal with a range of complaints and a mixture of emergency and elective admissions (see Chapter 3 for further details). The selection of the case study hospitals (described in detail in Appendix A) was based on considerations of access as well as purposive criteria. The use of a clustered comparative case study approach facilitates an analysis of how grievances arise and are articulated within the context of the 'hospital as workplace'. Miles & Huberman argue that "multiple cases offer the researcher an even deeper understanding of processes and outcomes of cases, the chance to test (not just develop) hypotheses, and a good picture of locally grounded causality" (1994: 26). In fact, common grievances are observed across different settings as well as more specific, local patterns.

The Composition of the Nursing Workforce in the Case Study Hospitals

In order to contextualise the empirical analysis of work grievances that follows, I will provide an overview of the demographic characteristics of nurses who responded to the questionnaire survey. Figure 5.1 illustrates the gender composition of the nursing workforce in the Irish and Italian case study hospitals and highlights the striking difference between the former, in which 99 per cent of nurses are female, and the latter, in which only 31 per cent of nurses are women. Interestingly, however, the percentage of female nurses within the Italian sample increases to roughly 50 per cent for nurses aged between 30 and 39 years and reaches 55 per cent in the youngest age bracket, 25-29 years. Thus, a trend towards the 'feminisation' of nursing in Naples is evident within this sample. By exploring the differences and similarities between male and female nurses in relation to work grievances and union representation, I will assess the relative importance of gender as an explanatory factor in relation to nurses' work grievances in the case study hospitals.

Figure 5.1 Gender Composition of the Case Study Hospitals

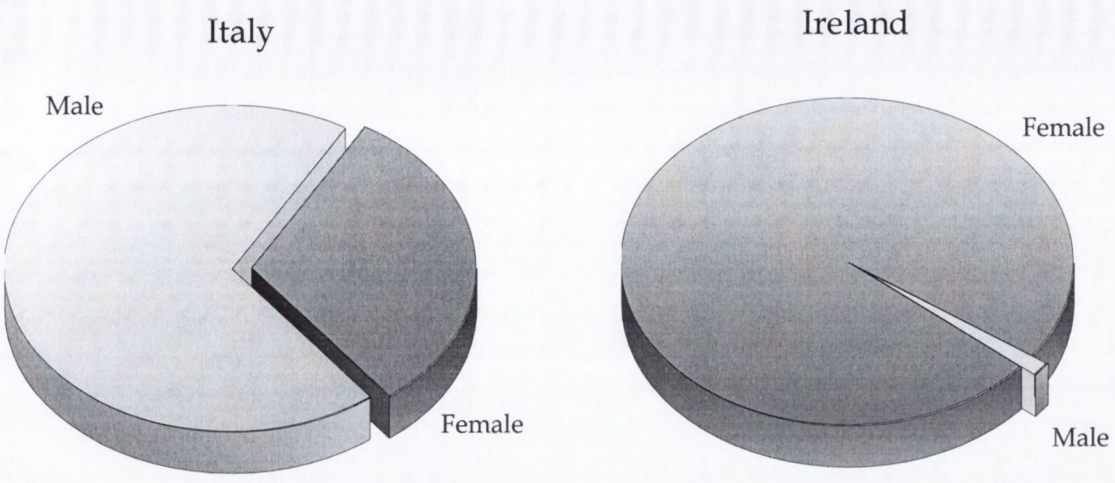


Figure 5.2 illustrates the age composition of the nursing workforce in the case study hospitals and reveals further differences between the two national contexts: whereas 87 per cent of nurses in the Irish sample are under 40 years of age, this applies to only 37 percent of the Italian nurses. This is accompanied by a marked difference in the number of nurses who are married: 80 per cent in Italy and just 18 per cent in Ireland. As far as working hours are concerned, the average for Irish nurses is a little higher than in Italy (39 hours per week, as compared to almost 37 hours respectively), and just under one third (30%) of nurses in the Irish sample are on temporary contracts, compared to less than one per cent in Italy. This underlines the relative attractiveness of state employment in Southern Italy, as this constitutes permanent, pensionable employment with minimal risk of redundancy or dismissal. In contrast, many employment opportunities in Naples are precarious and situated within the black economy.

Table 5.1 below provides a summary of the distribution of the survey respondents between different types of hospital ward. Although the categories utilised are rather rudimentary, they confirm the wide coverage of the survey. The main difference between the two samples is found in the proportion of nurses working in Accident and Emergency Departments. Whereas just over one tenth of Irish respondents work in this area of hospital care, this applies to roughly one quarter of the Italian sample. This imbalance is due to the sampling strategy adopted in Italy, as a large number of questionnaires were distributed in the Accident and Emergency Department of one of the case study hospitals (see Appendix A for further details on the selection of the case

study hospitals and the distribution of questionnaires). With this exception, the distribution of nurses across the other types of hospital ward is similar in the two national samples.

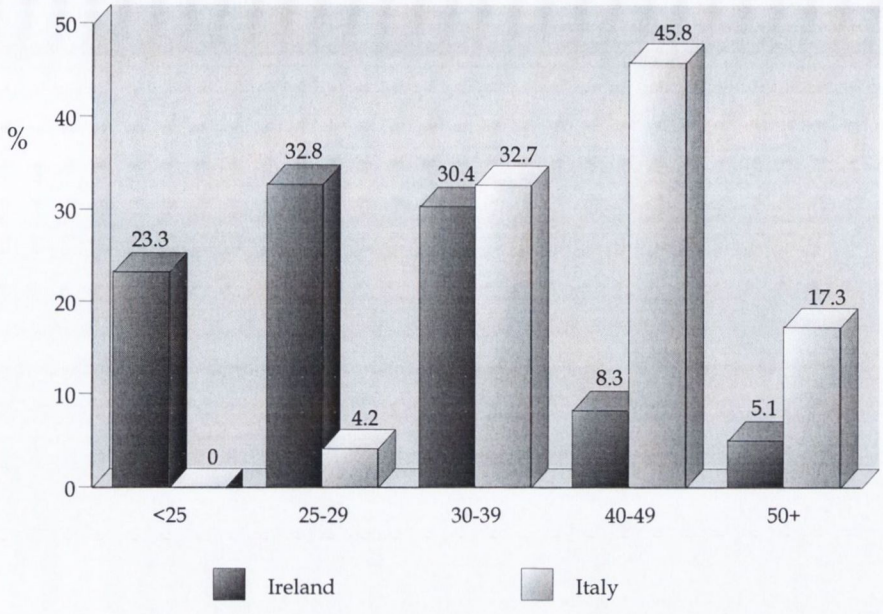
Table 5.1 Distribution of Nurses Between Wards[104]

	Ireland		Italy	
Ward Type	Frequency	Valid Percent	Frequency	Valid Percent
General Medical Ward	*35*	*13.9%*	*45*	*18.1%*
General Surgical Ward	*35*	*13.9%*	*21*	*8.4%*
Operating Theatres	*22*	*8.8%*	*19*	*7.6%*
Paediatrics/Maternity/Geriatrics	-	-	*18*	*7.2%*
Day Care	*4*	*1.6%*	*2*	*0.8%*
Accident & Emergency	*26*	*10.4%*	*63*	*25.3%*
Intensive Care	*23*	*9.2%*	-	-
Other	*106*	*42.2%*	*81*	*32.5%*
Total	*251*		*249*	

The marked contrast between the Irish and Italian samples in relation to gender, age and labour market situation will provide an opportunity to assess the relative importance of individual attributes and conditions of employment in shaping subjective work grievances. If individual characteristics such as gender and age have a greater weight in determining grievances, then we would expect to find considerable differences between the two samples. On the contrary, if working conditions and the nature of nursing represent the dominant influence in relation to grievances, then we would expect to find similarities between these two groups.

[104] Slight differences in the response options provided in the English and Italian versions of the questionnaire generated slightly different distributions for the two samples.

Figure 5.2 Age Composition of the Irish and Italian Samples



Theoretical Approach

It will be clear from the comments made earlier that I intend to distinguish between the grievances expressed by workers themselves and the demands or claims put forward by union organisations and spokespersons. In fact, it is important to appreciate the mediating role played by union representatives, who transform the largely implicit, inter-subjective understandings of workers into a list of demands amenable to negotiation. The main reason for distinguishing between workers' grievances and union demands – apart from the greater precision that this affords – is that this process of interpretation and expression can often give rise to tensions. For example, in all four of the hospitals studied during the course of fieldwork, nurses were critical of their unions for failing to address specific grievances.

At the most basic level, grievances may be seen as arising from contradictions between the needs or aspirations of a group of workers and their actual work situation. Because needs and aspirations are in continual evolution and are shaped by a range of social, cultural and political factors, an explanation for individual grievances can only be provided on the basis of a detailed empirical investigation. In this chapter, I will relate grievances to a relatively small number of *underlying contradictions* in the work

situation of nurses. I will use a typology of grievances to structure my account, based on a number of analytical distinctions.

I will distinguish between eight different types of grievance: the first includes grievances arising from nurses' aspirations regarding their remuneration, the second comprises issues related to the intensity, pace, hours or stressful nature of nursing work and the third involves 'professional' grievances which have to do with the status, autonomy, roles and responsibilities of nurses. The fourth category embraces grievances which arise from nurses' aspirations regarding patient care, where these clash with the quality of care provided or the availability of materials and facilities. The fifth involves health and safety issues, where nurses' working conditions impinge on the physical or psychological well-being of the nurse and the sixth comprises issues which arise from nurses' aspirations regarding their own facilities at work (changing-rooms, nurses' stations, chairs, beds, etc.). The seventh category of grievance is related to nurses' aspirations for non-oppressive work relationships – both with patients and with fellow workers – and the eighth embraces grievances that originate with nurses' aspirations for self-realisation. Table 5.1 below summarises these categories and indicates the source of the underlying contradictions.

Table 5.2 A Typology of Nurses' Work Grievances

	Type of Grievance	Source of Contradiction
1.	Wages & differentials	*Indeterminacy of the 'fair wage'*
2.	Intensity, pace and hours of work	*Impact of rationalisation*
3.	Status, autonomy, roles, responsibilities	*Role of nurses within hospital labour process*
4.	Quality of care, shortage of materials	*Resource constraints*
5.	Health and safety	*Cost of safeguarding nurses' health*
6.	Facilities for nurses	*Subordinate role of nurses*
7.	Bullying, inter-personal conflict	*Oppressive work relationships*
8.	Lack of professional growth	*Cost implications of 'professionalisation'*

It is worth reiterating that the distinctions implied by this typology are *analytical* in nature, and do not correspond to sharp boundaries in the consciousness of individual nurses. In fact, many of the issues expressed by nurses are related simultaneously to several different kinds of contradiction. This is because nurses' experience of work is not compartmentalised but involves a continuous and integrated totality of feelings and cognitions. Whilst it can be helpful to employ distinctions such as those provided in the table above in order to achieve a better understanding of work grievances, it is also important to understand how these are integrated in practice and how the different categories relate to each other.

Wages & Differentials

As I mentioned above, the interview data was analysed by inspecting condensed data displays which were organised in the form of matrices, some of which are reproduced in this chapter. The first category of grievance concerns wages and wage differentials. It is important to recognise that these grievances have a number of specificities. Firstly, they are linked with contractual conditions of employment and are potentially of interest to all nurses. Secondly, they are strongly 'mediated', as national union representation focuses on this area. Thirdly, wages are fundamentally indeterminate, as there is no rational way of determining 'a fair wage' for a given group:

> *[Researcher: The Staff Nurses themselves, how do they feel about their pay?] I'm sure they are not happy either (laughs). But nobody is ever happy.*[105]

Thus, like most employees, nurses' assessments of their earnings are made in relative terms, with reference to traditional 'comparators' and an implicit sense of the appropriate place of nurses in the 'occupational ladder'. Fourthly, wages grievances are related to the aspirations and needs of nurses *outside* their workplace. Naturally, because nurses typically evaluate their earnings in the context of their working

[105] Female Staff Nurse (32 years of age) in *Voluntary Hospital*, Interview 1-3. When providing interview extracts, I will enclose all questions and comments by the interviewer within square brackets for ease of interpretation.

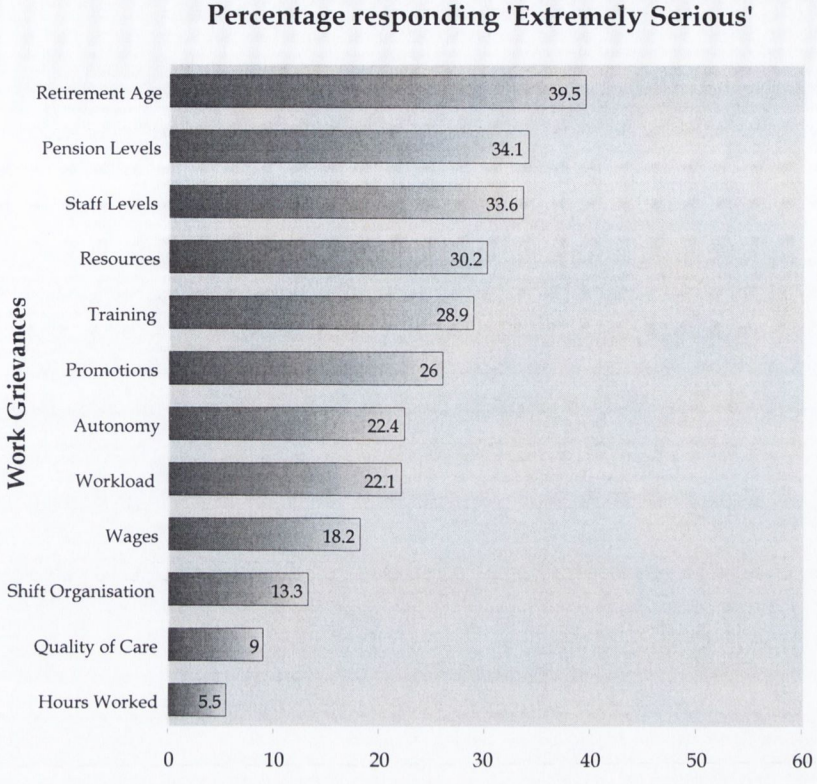
conditions as a whole, wages grievances are frequently intertwined with non-pay grievances.

One of the central paradoxes one encounters in relation to material grievances in nursing is that, on the one hand, individual nurses rarely express overt dissatisfaction with their basic rates of pay, whilst on the other, this issue clearly has the capacity to generate high levels of union militancy. Shortly after fieldwork began in the Irish case study hospital, a national nurses' strike took place – the first in the history of the Republic of Ireland (see Chapter Three). The strike aimed to obtain improvements in relation to long-service increments, pay differentials for promotional grades, bonuses for nurses who obtain additional qualifications and for nurses working in specialist areas. It came less than two years after nurses won an increase in basic pay of almost twenty per cent. Nevertheless, there was only limited evidence of dissatisfaction with wages amongst the nurses who were interviewed during the course of this research project.

The questionnaire survey conducted in the four case study hospitals reinforces this overall impression (see Figures 5.3 and 5.4)[106]. When nurses were asked to indicate which of a range of potential grievances were most important to them, they prioritised pensions and retirement age, professional development and promotions, staffing levels and resource shortages above wage levels. Just over one-quarter of the Italian nurses and less than one-fifth of the Irish sample described wage levels as 'extremely serious'. Whilst this certainly indicates a certain amount of concern, it stands in contrast to the 55 per cent of Neapolitan nurses and 34 per cent of Dublin nurses who described pension levels as 'extremely serious'.

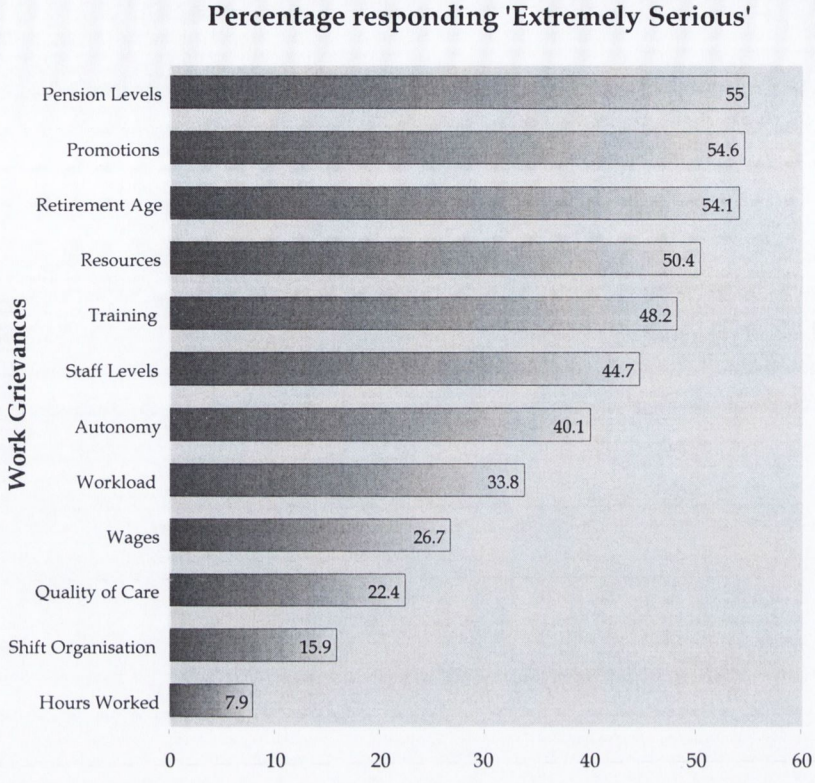
[106] The sample size for Figure 5.3 is 296 and that for Figure 5.4 is 559.

Figure 5.3 Perceived Work Grievances of Nurses in Dublin



The strength of feeling about pension levels and the retirement age amongst both groups of nurses is somewhat surprising, particularly as the Irish nurses have an average age of just over 30 (compared to 42 for their Italian counterparts). Although this issue was mentioned by very few nurses during the interviews, the responses most likely reflect fears about having to perform a physically-demanding job up to and beyond 60 years of age as well as concerns about future income levels. As I will show later, when I report on the results of a series of regression models, nurses working in Theatre and Accident & Emergency Departments appear to be particularly concerned about retirement age and pension levels, perhaps due to the intensity of nursing work in these areas. In Ireland, the retirement age for nurses has acquired greater prominence in recent years as increasing numbers of nurses have chosen to remain in employment after getting married, and because General Nurses (in contrast to Psychiatric Nurses) do not have the option of taking early retirement.

Figure 5.4 Perceived Work Grievances of Nurses in Naples



The following tables provide an indication of how nurses perceive their overall working conditions to be changing, and confirm that these perceptions are highly negative in both countries: only 11 per cent of the Italian nurses and 19 per cent of the Irish nurses felt that their working conditions had improved over the previous year, and when asked about the future, only 14 per cent of Italian nurses and 12 per cent of Irish nurses expected them to improve.

Figure 5.5 Perceived Changes in Working Conditions

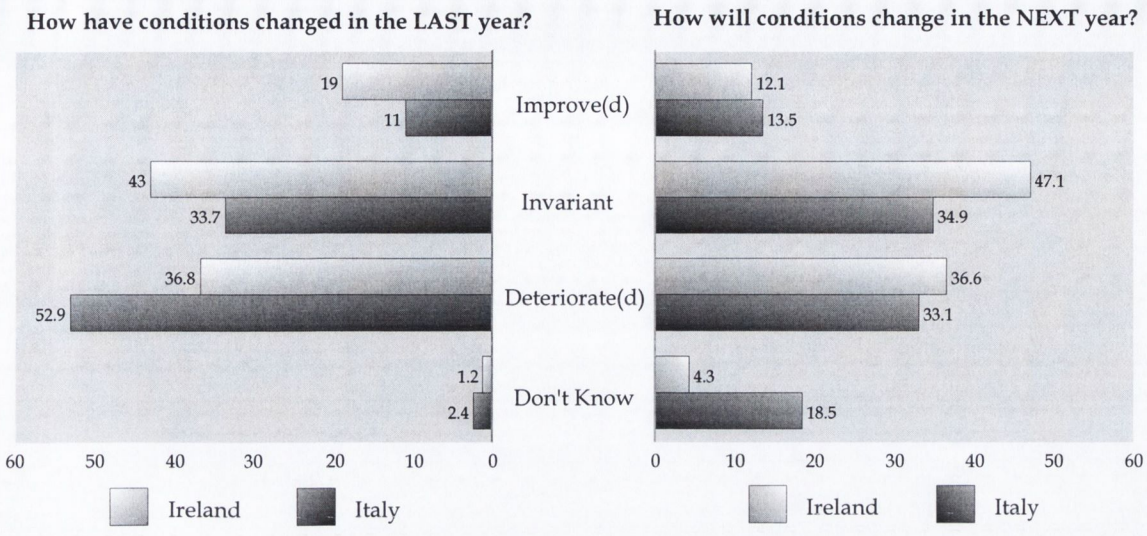


Table 5.3 below summarises the opinions of Italian nurses in relation to wage levels and provides a cross-section of the views expressed by the interview volunteers. The extracts have been edited in some cases to produce a more succinct statement (omitted text is indicated by three periods ...). The interviewer's questions and comments are enclosed between square brackets [] and interruptions are indicated by two forward slashes //. The table provides information on the hospital, age and gender of the interviewees concerned (the first hospital is *Voluntary Hospital*, the Irish hospital, the second is *Azienda*, the third *Presidio* and the fourth *Emergency Block*, which forms part of another large, acute hospital in Naples). All extracts from interviews with Italian nurses were translated by the author, with the aim of remaining as faithful as possible to the meaning of the original text. Where additional explanations or clarifications are necessary, these have been provided between brackets.

Table 5.3 Wage Grievances of Nurses in Case Study Hospitals

Extract No.	Hosp. No.	Age	M/F	Extract
1.	No. 2	47	M	*... at the moment I'm on holiday ... I can't go anywhere because with a family of six and with my salary, the rent that I pay and the electricity, gas and phone bills...*
2.	No. 2	45	M	*There's a lot of dissatisfaction amongst those of us who work in the city hospitals, because there's little recognition ... In my opinion nurses are underpaid – just think that a nurse who doesn't work shifts, who doesn't work nights, hardly earns ... one million seven*[107]
3.	No. 2	44	M	*... I don't believe that all nurses do their job ... with pleasure, because it's also a fairly unpleasant job. Therefore it's only fair that ... the wages should be better, because we need more than just moral gratification ...*
4.	No. 3	54	F	*I live with my mother, because my income is too low. I'm not married – I have a child but I'm not married ... [If you were to buy a house and everything?] I can't, absolutely not. No way, that's my dream!*
5.	No. 3	45	M	*Last year I had the possibility of changing jobs, I could have come here to work in the district health service, but my choice was determined by economic considerations. Because working for the district implies ... a drop in income, and mine is the only wage, with four children, three at secondary school, I obviously had to bite the bullet*

In addition to criticism and dissatisfaction, there were also cases of nurses who expressed relative satisfaction with their current wage levels:

> *You know, the money is not too bad now and it's a good stepping stone, you can go anywhere you want to, you can travel anywhere with it, you know.*[108]

[107] One million seven hundred thousand lire are equivalent to just under nine hundred Euro.

[108] Female Ward Sister (42 years of age) in *Voluntary Hospital*, Interview 1-9. Note that the Irish case study hospital is identified as *Voluntary Hospital*.

The majority of the Irish interview volunteers, in common with their Italian counterparts, were critical of current wage levels (although, as noted above, the amount of dissatisfaction expressed by the interviewees was lower than in other areas):

> *I was out last night with some friends of mine. We are all the same age, and they're earning, some of them, nearly twice my salary! And I do think about it sometimes and think "God, what am I doing, I'm working for a pittance".*[109]

It is interesting to relate these statements to the motivations that led nurses to choose nursing in the first place (Table 5.4), as the primary motivation in many cases was economic, particularly for the Italian interviewees, many of whom had few options when they entered the labour market. Indeed, for many Italian nurses, the choice of nursing was either imposed (Extract No. 17) or purely accidental (Extract No. 10 and No. 25), although cases of a family tradition (Extract No. 11) or positive career choice (Extract No. 14 and No. 24) are not entirely uncommon. Whereas the Irish nurses occasionally mention economic factors, they were typically led towards nursing by other considerations, typically of a more 'vocational' nature.

[109] Female Staff Nurse (31 years of age) in *Voluntary Hospital*, Interview 1-2.

Table 5.4 Motives for Entering the Nursing Profession

Extract No.	Hosp. No.	Age	M/F	Extract
6.	No. 1	31	F	*Well, it was more by accident than anything else. So I just applied for nursing and I applied for college as well, and I started doing ESS in Trinity and I didn't like it, it was just too business-orientated for me*
7.	No. 1	33	F	*I went to school at a convent school – it was either you were channelled towards teaching or nursing and I couldn't sing or speak Irish so teaching was out! ... A couple of my aunts were nurses as well so I suppose they kind of influenced me a little bit*
8.	No. 1	28	F	*So there was a job going down in the Nursing Home my Mum worked in and I said "Gosh, I've always wanted to try nursing, I'll give it a bash". So I started working there as a Nurse's Aide for about a year and a half, on nights. Absolutely LOVED the work, ADORED it*
9.	No. 2	42	M	*My intention was only to earn some money and continue at university*
10.	No. 2	42	F	*... I was studying at university but I wanted to work – I had to work, because I was the eldest in a large family – and I started (working as a nurse) by pure chance*
11.	No. 2	47	M	*My father used to be an army officer, also in the Navy – he was a nurse, that was his occupational category – and given this family tradition ... I chose nursing*
12.	No. 2	42	M	*... I had never intended to become a nurse ... One time my father-in-law advised me, he said 'why not do a course to become a hospital technician?' I said no, there was no way I was going near a hospital...*
13.	No. 2	49	M	*How did I end up being a nurse? Let's just say it was because I needed a job, at the beginning*
14.	No. 2	42	F	*[Why did you choose nursing?] Because it appealed to me, I believed in it. [Even as a girl, did you always have that idea?] Yes, even as a young girl*
15.	No. 2	44	M	*To tell the truth I chose it because I didn't have any other possibility of entering the world of work. Certainly as far as I was concerned ... it's not that I actually wanted to become a nurse*

Table 5.4 *Continued*

Extract No.	Hosp. No.	Age	M/F	Extract
16.	No. 2	43	M	*... I did the Red Cross course in Professional Nursing, because it seemed like there were good possibilities of getting a job, and later I fell in love with the profession*
17.	No. 2	41	M	*Personally, I never chose it – because we were a group of unemployed – it was the only opening, basically, and there were no other options*
18.	No. 2	53	M	*I'll be honest with you, it's not that I had a 'vocation' ... I was taken on as an auxiliary ... and the only possibility of improving myself in professional terms ... was to go and do the course*
19.	No. 2	52	F	*[You said that at the beginning you entered the hospital more or less for personal reasons?] Yes, because I was out of work and I had three children to bring up. I had no alternative but to look for work*
20.	No. 2	39	M	*You could say that ... I didn't choose this job ... because I had done a course in Accountancy ... at the time the health service represented the only doors that were still open ...*
21.	No. 3	45	M	*... in my case – I had trained as a skilled metal-worker – but I NEVER had the chance of even getting close to a factory. So at that stage I decided to do the course to become a Professional Nurse ...*
22.	No. 3	53	M	*At the beginning, it's not like I actually decided to become a nurse. It was basically a landing pad that presented itself, many years ago, in 1963. And because I didn't want to study any longer I became a nurse*
23.	No. 3	45	F	*My choice was to work, because I couldn't find a job using my diploma. [What diploma do you have?] A diploma from a technical school, in languages*
24.	No. 3	31	F	*... I started this course at just 15 years of age ... because I have a sister who is much older than me ... who was already working as a Midwife and it ... fascinated me*
25.	No. 3	36	M	*... by pure chance I met a friend in the street ... "I'm sending in my brother's application form for a nursing job". Quite honestly, I had always had this thing, and I said: "I'll do the same thing myself"!*

Table 5.4 *Continued*

Extract No.	Hosp. No.	Age	M/F	Extract
26.	No. 3	54	F	*... I always liked being with children. I would have liked to have become a Paediatrician ... but there were difficulties: I was the oldest, and my family... There was no money, my father was sick ...*[110]
27.	No. 3	35	M	*... to give you a straight answer, it was the need to find work, because after qualifying as an electrician ... This was one of the opportunities, one of the schools that, at least at the time, was almost guaranteed to lead to a job ...*

The main reason for the absence of strong, direct criticisms of overall wage levels is that the aspirations of nurses in both countries are currently focused on promotions, incentives and differentials as a means of improving their remuneration. This 'particularistic' formulation of wage grievances corresponds to a relatively defensive orientation, as it relies on the notion of the 'deserving case' rather than the pursuit of a generalised wage claim. Table 5.5 summarises the Irish interview extracts in relation to this issue and Table 5.6 contains the Italian data.

In Ireland, grievances regarding incentives and differentials are widespread, and are frequently linked with the demand for some form of financial recognition for additional qualifications. Irish nurses (at least those in the acute hospitals in Dublin) frequently acquire a second nursing diploma (in Midwifery, for example) or a nursing-related specialisation. During the interviews with Irish nurses – carried out prior to the first national nursing strike in 1999 – the issue of financial recognition for additional qualifications was raised by nearly all of the interviewees (see Table 5.6 below).

[110] The interviewee in this extract is a *Puericultrice*, a category that has now been replaced by the *Vigilatrice d'Infanzia*, and which has responsibility for the care of newly-born babies in Maternity wards.

Table 5.5 Grievances of Irish Nurses Regarding Incentives and Differentials

Extract No.	Hosp. No.	Age	M/F	Extract
28.	No. 1	31	F	*The scope for promotion within the job is very poor ... It is just so difficult to get anywhere. And then you do courses, you go back to college and you spend £3,000 if you are doing a diploma course ... You don't get the time off ... and you get no more money at the end of it*
29.	No. 1	32	F	*I think pay is a HUGE issue for nurses, I know it is for me. My job, I'm a Junior Ward Sister and yet the Staff Nurses on the ward get paid more than me*
30.	No. 1	35	F	*...speaking as a Ward Sister, I mean the Ward Sisters' salary increase was ABYSMAL in terms of, if you compare it to the top end of the scale of the Staff Nurse ... There is no differential!*
31.	No. 1	25	F	*It's the same with, like, Intensive Care or any highly-specialised areas. Every area is stressful but it's particularly more stressful ... [On that basis do you think you should be paid more than people in more relaxed wards?] Yeah, I do*

Table 5.6 Grievances of Italian Nurses Regarding Incentives and Differentials

Extract No.	Hosp. No.	Age	M/F	Extract
32.	No. 2	47	M	*While the others were celebrating (on New Year's Eve), we were working, and it's not fair that they should receive the same salary ...*
33.	No. 2	42	M	*Therefore, there should be some form of recognition, because it is not fair that a nurse who works ten hours a day in the front line, in Intensive Care, or in an operating theatre, should be at the same level as other nurses ...*
34.	No. 2	36	M	*... why should we have to work in Theatre with a greater burden of responsibility, working the way we do, keeping ourselves up to date, only to earn the same wage ... as a person who ... can sit around waiting for the drug round ...*
35.	No. 2	53	M	*... if I study hard, keep studying and all the rest of it, I will be able to give the enterprise a better service, and my remuneration level should also be different from somebody who couldn't care less*
36.	No. 3	36	M	*... I work in Theatre, in an enclosed space, and those who can breathe fresh air earn the same money as me*

A large number of examples of this type of grievance could have been provided, but as these are largely repetitive, I have decided to provide only five extracts from Italian nurses. The notion of the 'special case' is interesting, as all nurses can provide a plausible case for 'deserving' a wage increment, and not only those who work in Critical Care, Theatre or in a so-called 'specialist area' (e.g. Oncology). For example, nurses working on the wards point out that they must cope with emergencies on their own, without having medical staff on hand at all times, that they must deal with the social and psychological aspects of nursing care and interact with patients' relatives. Given that activity levels have risen considerably in all areas of the hospital, and increased patient throughput has reduced or eliminated 'slack', it is not easy to sustain the greater 'deservingness' of any given ward or type of ward in terms of the nature of the labour process.

The extracts quoted above emphasise work intensity, stress, working conditions and responsibility at ward level. However, it is also possible to construct an argument for wage differentials in terms of education levels and training:

> *... why should you sacrifice yourself for three years, in order to go and do a course, because afterwards... All these courses that you go and do weigh upon the relationship between the nurse and his or her family ... If I subtract time from my family, I have made a sacrifice, and even my children and my wife have to make a sacrifice. And therefore there should be some recompense for having made this sacrifice.*[111]

The question of wage differentials highlights an important issue within the Italian labour movement, namely the issue of egalitarianism versus differentials. As I suggested in Chapter Three, opposition to the union confederations' adhesion to incomes policy during the 1980s often took the form of sectoral campaigns (e.g. COBAS-Scuola) or a demand for special treatment (industrial action by medical staff and pilots, for example). In fact, it is relatively common for nurses to link their wage demands with a critique of the traditional union confederations (CGIL, CISL and UIL):

[111] Male Staff Nurse (42 years of age) in *Azienda*, Interview 2-5.

THAT should be the task of the unions, not saying "let's give everybody 100,000 (lire) extra", because that's not what we are looking for, but rather "let's see where can we give a bonus to somebody who deserves it, on the basis of the work that they do", and ensure that for one year, one person gets it, and for another year somebody else.[112]

A sense of egalitarianism remains firmly entrenched within the consciousness of Neapolitan nurses. The *leitmotiv* of the union struggles of the late 1960s and early 1970s in Italy was the pursuit of fixed-sum wage increases (*uguali per tutti*) which reduced differentials and generated feelings of solidarity within the labour movement, reflecting the collectivism of working-class struggles in this period and the unity of the three union confederations. This helps to explain why interviewees advocating a greater differentiation in retribution within the nursing profession have a tendency to revise their position when challenged regarding the inequalities that this would create:

If there's more professionalism, more work gets done and therefore the income of the enterprise goes up ... and you also need an economic incentive ... [Researcher: What about the inequalities that this would create between nurses?] But there wouldn't be any inequalities, because we are talking about professionalism. ... And at any rate there would be no inequalities, because we would all receive the same money, basically, therefore... At the end of the day, we would all get the same, there would be no inequalities. How could you create a situation where a nurse in one ward earns more and somebody in a different ward earns less?[113]

Several other extracts could be provided to reinforce this point, as there is widespread commitment to an egalitarian system of retribution in Naples. This commitment is constantly reinforced by suspicions regarding the attempts of other nurses to improve their situation by bending the rules:

[112] Male Staff Nurse (36 years of age) in *Azienda*, Interview 2-11.
[113] Male Staff Nurse (41 years of age) in *Azienda*, Interview 2-19.

> *... for example, there are people who ... nurses who earn a lot of money because they have been allocated to wards where they can do lots of overtime – 40-50 hours a month – I don't know if you catch my drift – and they are basically just nurses, have always been nurses, but they have people looking out for them.*[114]

On the basis of the evidence presented here, it is clear that similar developments – the increasing specialisation within nursing, the greater intensity of work and the aspirations of nurses regarding their remuneration – have led to demands for greater wage differentials within the nursing profession in both Ireland and Italy. Whereas in Italy, these demands are counterbalanced by a commitment to egalitarianism, in Ireland there is little evidence of this, perhaps due to the more individualistic culture of Irish nursing (see Chapter Six).

The demand for wage differentials may be viewed as a *defensive* demand, which takes as its point of departure existing limitations on resources and seeks to articulate a claim for 'special treatment' on behalf of a minority of nurses. It is interesting, in this context, that during the course of the nurses' pay campaign, and in the lead-up to the national strike in 1999, young nurses who had previously been relatively inactive within their union began to voice wages grievances of a more 'general' nature, counterbalancing the demand for 'differentials' which had previously dominated debates (see Chapter Three).

Intensity, Pace and Hours of Work

The second 'family' of grievances relates to the intensity and duration of work, and arises from the nature of the labour process in the public health service. Table 5.7 summarises the statements of the Irish interviewees in relation to workloads, and Table 5.8 provides an analogous picture of the opinions of nurses in Naples. The extracts in these tables show that the experience of nurses in both countries is remarkably similar: in recent years the pace of work has increased sharply and the resulting increases in workloads create severe difficulties for nurses in relation to their own stress levels, their ability to care for their patients, their working hours and their job satisfaction.

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[114] Male Staff Nurse (47 years of age) in *Azienda*, Interview 2-4.

Table 5.7 Grievances of Irish Nurses Regarding Workloads

Extract No.	Hosp. No.	Age	M/F	Extract
37.	No. 1	25	F	*... you don't have time for people. And things get missed. Like I was on yesterday evening and the place was just MANIC. I was running all day and still I felt ... And I just discovered I hadn't seen one of my patients for three hours ... She'd had like eight episodes of diarrhoea ...*
38.	No. 1	31	F	*Even though administration will tell you that you have your quota of staff on a particular ward, our numbers since this time last year are greatly reduced. There is over-crowding, there is stretcher beds up everywhere, two wards closed ...*
39.	No. 1	33	F	*[It would be a regular occurrence to have an extra bed?] Interviewee: It's an irregular occurrence NOT to have one*
40.	No. 1	35	F	*I am here 15 months, but I know the figures for patient attendances for the last few years, and they have gone up by 2,500 to 3,000 patients per year .... We haven't gotten extra seating, we haven't gotten extra bathrooms, we haven't gotten extra facilities*

Table 5.8 Grievances of Italian Nurses Regarding Workloads

Extract No.	Hosp. No.	Age	M/F	Extract
41.	No. 2	42	M	*It's precisely the Senior Consultants who are in greater demand ... they operate on a larger number of people each day, reduce the length of stay of the patients in the ward, and when a bed is vacated, they admit another patient immediately*
42.	No. 2	36	M	*... with three nurses on duty, they had two Operating Theatres on the go at the same time. In the Theatre where they do the more serious operations ... there were two nurses, in the Theatre where they implant pacemakers there was only one ... Crazy stuff...*
43.	No. 2	36	M	*Exhaustion and stress lead to lapses in attention – for example, this is a burn that I got yesterday evening, because after 12 hours of work ... I bumped against the autoclave*[115]
44.	No. 2	43/ 46	M/ M	*First Interviewee: Our working conditions have deteriorated, because our workload has become VERY heavy, in terms of its pace ... Second Interviewee: Every year, with the DRG system, we are carrying out many, many more treatments each year – we have seen the registers*
45.	No. 2	46	M	*The nursing staff here not only do their regular working week, but also double up, because basically you have to cover the vacant shifts. So you tell me, what can you expect from a nurse, having worked from eight o'clock in the morning to eight o'clock in the evening?*[116]
46.	No. 2	42	M	*It's rare for somebody to want to come and work here in Urology, because it is a ward with a very, VERY heavy workload... And the work itself is tough [Physically hard?] Also physically hard. Both mentally and physically, this ward destroys you ...*
47.	No. 3	34	M	*... I can assure you that over the course of the year we hardly ever have empty beds. ... The ward is nearly always full, which means that we are always working at a very high level*
48.	No. 3	34	M	*For management, we seem to be just workhorses: they expect you to turn up and to do whatever there is to be done. I don't ever remember them coming to ask whether we were having any problems or whether we had any aspirations of our own*[117]

[115] The interviewee is the same in Extracts No. 42 and No. 43, but both have been included due to their intrinsic interest.
[116] The second interviewee in Extract No. 44 is also the source of extract 45.
[117] The interviewee in this extract is the same as in the previous extract.

Table 5.8 ***Continued***

Extract No.	Hosp. No.	Age	M/F	Extract
49.	No. 3	59	M	*And because this is a front-line hospital, an Accident and Emergency hospital ... there is a lot of work, whereas in the more peripheral hospitals the workload is much lighter*
50.	No. 3	36	M	*[Have your workloads increased, compared to the past?] The general trend is upwards. But even compared to other Operating Theatres, in other hospitals, we work much harder*

The main reason for the increase in workloads is the failure of staffing levels to keep pace with the increases in patient throughput and dependency levels that occurred during the 1990s. In all three of the Neapolitan case study hospitals staffing levels actually declined during the 1990s, due to natural wastage and transfers. In *Presidio*, for example, a reduction of 70 nurses occurred (26%) in the space of six or seven years. This was due to nurses reaching retirement age (and in a few cases due to mortality), but there were also numerous transfers to hospitals outside the city of Naples. These transfers were sanctioned by administrators from the *ASL*, who were concerned to reduce overall staffing levels in the metropolitan hospitals in an attempt to reduce costs.

In Ireland, staffing levels were adversely affected by the student nurses' shift to supernumerary status and by the 'recruitment crisis', which manifested itself towards the end of the 1990s. The response of management was to increase flexibility in terms of working hours to coax nurses back into the health service, to expand the 'Ward Attendant' grade, to improve their advertising strategy and to make extensive use of agency staff (who are often hospital nurses working during their free time). A Nurse Manager provided the following comments:

> *[Researcher: So you're up to quota?] Yeah, but meeting the increased Staff Nurse numbers has now become difficult because everybody is dipping into the same pot. Because all the major hospitals have gone into the same programme. [Researcher: In Dublin?] Yes. [Researcher: Has nursing management had to change its recruitment criteria?] Yes (without any hesitation), we have, we have (pause)*

advertised more widely, we've changed contracts. We have worked both on the recruitment end and retention.[118]

Tables 5.9 and 5.10 below provide a summary of the attitudes of nurses in the case study hospitals towards staff shortages, and underline the central importance of this issue. Because of their overall responsibility for their patients, staff shortages have an immediate impact on nursing staff, even where these shortages are in adjacent occupations. Nurses typically seek to compensate for shortcomings in patient care due to shortages, and the commitment of nurses to their patients' well-being then becomes a double-edged sword. This is a source of 'moral blackmail', ensuring that restrictions on recruitment are translated into an overall increase in work intensity. The rationalisation of the hospital network (leading to the closure of a number of small hospitals) has had a similar effect, as the number of patients attending the remaining hospitals increased.

Thus, grievances involving staffing levels and workloads are linked with the rationalisation of public health care in Ireland and Italy during the 1990s. In Ireland, because of the tendency for more serious cases to be sent to the acute hospitals in Dublin, the latter have suffered a disproportionate increase in their activity levels. Although this has generated serious problems of overcrowding in certain wards, it is difficult for hospital staff to turn away patients. The following quote from a hospital union representative shows how the nursing unions have started to tackle this issue:

Well, I think that more than 'nurses have a responsibility towards the health service being delivered' I think nurses need to ensure that we're giving a good quality health service. It's not our responsibility to ensure that there's enough money – that's the Department of Health and the Government's responsibility. It's not our responsibility to stretch ourselves to a limit, at a time when there's new technology and new things happening.[119]

[118] Female Nurse Manager in *Voluntary Hospital*, Interview 1-11.
[119] Female Psychiatric Nurse (aged 32 years) in *Azienda*, Interview 3-7.

Table 5.9 Grievances of Irish Nurses Regarding Staff Shortages

Extract No.	Hosp. No.	Age	M/F	Extract
51.	No. 1	33	F	*I mean, we are running at about three nurses below what we should have. (pause) I mean I think what we have been allocated is probably sufficient.. [...if they were all there?] Yeah, but they're not*
52.	No. 1	25	F	*[To what extent do you think the short-staffing is attributable to that, to taking the students off the ward?] It's hugely, it's one of the main issues*
53.	No. 1	25	F	*There's officially twenty beds, but today for instance there are twenty three, we've got three stretchers and there are two of us, two qualified staff came on on the evening shift and there's one (person working a) long day who's just started in the hospital a week ago*[120]
54.	No. 1	42	F	*Short staff probably is the biggest thing. [Yeah? And does that date back to last year, how long has this been going on?] I'd say probably about four years now. ... But certainly in the last two years there's been a big problem here with retention*

Table 5.10 Grievances of Italian Nurses Regarding Staff Shortages

Extract No.	Hosp. No.	Age	M/F	Extract
55.	No. 2	36	M	*Then what happened is that we have remained just eight nurses, but our workload has doubled, because we now have to work in two Theatres, with two different specialties ... and with the staff for just ONE Theatre ...*
56.	No. 2	42	F	*So we created two shift teams comprising two nurses. [How many beds are there in Urology?] There are 25 at the moment, but we have one room closed for renovation. So basically we would have 30-33 ...*
57.	No. 3	31	F	*There were originally three of us per shift, but in the space of five years that had fallen to two per shift ... With only two people you try to keep an eye on the ward, on the Operating Theatre, the* Sala Travaglio *and the* Sala Parto[121]
58.	No. 3	48	M	*... more often than not you ask for a day off, and the Medical Director of the ward refuses your request because he or she doesn't have enough staff. It has reached the stage where I lost six days of statutory leave last year, I wasn't able to use them*

[120] The interviewee in this extract is the same as in the preceding one.
[121] The interviewee in this extract is a Midwife working in a Maternity Ward.

The anger of Italian nurses in relation to staffing levels is accentuated by the fact that the resulting burden is typically not shouldered equally by all members of the nursing workforce. As I noted earlier, there is a strong commitment to egalitarianism amongst nurses, and this is also due to the disparities and anomalies generated by the tradition of clientelistic management. As I will show in Chapter Six, these inequalities in treatment are attributable not only to a clientelistic management style but are frequently sustained by local union representatives, who maintain membership levels by practising a clientelistic form of union representation based on the exchange of 'privileges' for subscriptions.

The rigidity of the shift system in the Italian hospitals, involving rotation between morning (8am – 2pm), afternoon (2pm – 8pm) and night (8pm – 8am) shifts, over a five-day cycle (morning; afternoon; night; recover from night shift; day off), has both advantages and disadvantages for nurses. In particular, this shift pattern has a high cost for female nurses, many of whom have family responsibilities:

> *The worst thing is that, in order to do this job, I am forced to work shifts, and therefore I don't have the freedom that I want, because during the holidays... For example, this year at Christmas, New Year and Epiphany I had to work. And for a woman who gets married, and therefore becomes both mother and wife, all this becomes a burden. Working women still have to bear the burden of being women, mothers, wives... And our husbands don't accept the idea of the woman who works for a wage at the end of the month.*[122]

Status, Autonomy, Roles, Responsibilities

The third family of grievances arises from the specificities of nurses' role within the hospital labour process, and in particular their subordinate status with respect to medical staff, their relative lack of autonomy and the amorphous nature of their work role. Nurses themselves sometimes refer to these grievances as 'professional' grievances, and I will consider this appellation in some detail below. Tables 5.11 (Ireland) and 5.12 (Italy) below summarise the evidence provided by the interviews.

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[122] Female Midwife (45 years of age) in *Presidio*, Interview 3-6.

Table 5.11 Grievances of Irish Nurses Regarding Their Status and Role

Extract No.	Hosp. No.	Age	M/F	Extract
59.	No. 1	31	F	*I suppose we've all been juniors, and we've all been there and done the ward work, and stuff, and we've done the grafting, and now it's our turn to be senior. But now there is no traditional students any more and there wouldn't be as many diploma students*
60.	No. 1	25	F	*... like our Orderly is always off covering a few different wards and we're expected to do things that aren't our role ... so you're answering phones all day when you're supposed to be looking after patients and making appointments, ringing outpatients, booking ambulances ...*
61.	No. 1	28	F	*The same with running up and down to the kitchen: there are girls there that do the kitchen, and you say "look, would you make bed 16 toast please". But if they say "Gosh, I can't, look I'm run off my feet", if you don't do it the patient goes hungry. So at the end of the day we are own worst enemies*

Table 5.12 Grievances of Italian Nurses Regarding Their Status and Role

Extract No.	Hosp. No.	Age	M/F	Extract
62.	No. 2	42	F	*If anything goes wrong, it's the nurse's fault, certainly not the doctor's*
63.	No. 2	50	M	*... you can't tell me how to sterilise something, or how to prepare a piece of equipment, or how to prepare a patient. They (doctors) refuse to understand that. ... Let's just say that they see us as (pause, looking for the right word) manual labourers!*
64.	No. 2	52	M	*... ten years of refusing to clean bed pans, to wash and clean them. ... In order to avoid this task, which is humiliating for our profession – somebody who has studied for so many years ...*
65.	No. 2	42	M	*In Italy, and in the South above all, the nurse is not viewed as 'the nurse', but is 'the person who gives the injections' ... He/she is not seen as somebody with professional training*
66.	No. 2	48/ 41	M/ M	*First Interviewee: So as time goes by, you become an employee who carries out certain tasks and that's all. Second Interviewee: The common denominator is the power of the medical profession. Our relationship with doctors is what has disappointed us*

Table 5.12 *Continued*

Extract No.	Hosp. No.	Age	M/F	Extract
67.	No. 2	48	M	*Another shortcoming that nursing staff experience in this hospital is the lack of an autonomous Nursing Management, which has nothing to do with management by doctors*[123]
68.	No. 4	44	M	*... teamwork is important, but it has never even existed here, either with our previous Medical Director in the ward, who I always ended up arguing with because he saw the nurse as the person who brings the patient's records, leaves them on the bed and goes away again*

Table 5.12 could easily be extended to include many more examples of the frustrations of Italian nurses regarding their role and status within the hospital. Like their Irish counterparts, Italian nurses frequently bemoan the lack of training courses within the hospital:

> *One of the things that we are lacking in this hospital, for example, are training courses. By law, they should be compulsory. The government even provides funding, but we know nothing about it, these courses have never taken place. Therefore, many of my colleagues are falling behind – maybe even I have fallen behind since I got my diploma, in certain respects – in relation to new techniques.*[124]

In relation to 'professional' grievances, a clear difference is apparent between Ireland and Italy, Irish nurses having a greater possibility of focusing on 'nursing duties'. One of the issues that was emphasised repeatedly by nurses in *Azienda* was the fact that nurses are forced to spend long periods of time outside their wards, accompanying patients during diagnostic tests, as well as collecting results and pharmaceuticals. Because of the shortage of auxiliary staff, whose job this would normally be, nurses are forced to take on these 'non-nursing duties':

[123] The interviewee in this extract is the same as the first interviewee in the preceding extract.
[124] Female Staff Nurse (34 years of age) in *Azienda*, Interview 2-10.

Everything has to be done during the morning, because that is when the services are in operation. Therefore, patients have to go down to the diagnostic services – who goes with them? The nurse! And he/she is subtracted from his/her formal work role. When one nurse accompanies a patient, only one is left in the ward, and they have to do all the IV and intramuscular treatments... So it is only the task – the technical procedure – that gets done. There's no question of sitting down beside the patient and asking him/her "how are you feeling?"[125]

When evaluating issues such as these, it is important to maintain a broad perspective and not to take the existing structure of roles as fixed. Many grievances regarding nurses' status and roles arise from the technical division of labour within the hospital labour process, and in particular from the definition of the 'medical' and 'nursing' roles and their construction as asymmetrical and complementary. Because medical staff are socialised to view the healing process primarily as a process of 'curing' pathologies, nursing care tends to be viewed in subordinate terms as the implementation of therapeutic decisions rather than as an autonomous discipline. This downgrades the 'therapeutic relationship' between nurses and their patients and the importance of the clinical, social and psychological aspects of nursing care. Thus, the prior 'professionalisation' of medicine (during the nineteenth century) shaped the hospital division of labour, relegating nurses to a subordinate role.

Nevertheless, it is important to stress that the technical division of labour unites as well as divides health workers, as it requires a large amount of cooperation between different occupational groups. In fact, many nurse interviewees felt that they had a good relationship with the doctors working in their wards. Thus, it would be a mistake to argue that doctors *in general* are responsible for the subordinate status of nurses or that the medical profession as a whole is the main obstacle to the resolution of nurses' 'professional' grievances. As the extracts from the Italian interviewees indicate, the failure of hospital managers to provide the resources required by ward-level nursing staff and their reluctance to consult nurses about issues regarding the organisation of patient care are equally important.

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[125] Female Unit Nursing Officer in *Azienda*, Interview 2-1.

The preceding discussion has not dealt with the question of what it actually means to be a 'professional'. The nursing research literature has provided a number of responses to this question and indicates several potential strategies for tackling nurses' grievances. It is valuable to review this literature in the light of the evidence collected during the course of this project and to assess its underlying assumptions.

The majority of contributions to the 'nursing research' literature advocate 'professionalisation' and attribute nurses' professional grievances to the failure of nursing to make the transition to full 'professional' status. This is variously attributed to cultural factors, the power of the medical profession, patriarchal structures, inherited models of hospital organisation or the shortcomings of nurse education (Bellaby & Oribabor, 1980; Davies, 1980, 1995; Garena, 1994; Saccheri, 1994). For example, Saccheri (1994) stresses the role of the medical profession and institutional traditions in relegating nurses to a secondary and dependent position within health care. The professional attributes of nurses are marginalised, with the result that a mechanistic model of care predominates: because of their lack of autonomy, nurses themselves begin to view patients as objects.

Saccheri makes a number of suggestions for improving nurses' situation, stressing the importance of training and the possibility of exchanging experiences, as well as a greater emphasis on specialisation and managerial skills amongst recently-qualified nurses. Indeed, the latter are considered the vanguard of a 'new professionalism', a recurrent motif in the nursing research literature. She argues, moreover, that it is necessary to increase the internal stratification of the profession, creating a genuine career structure. Garena (1994) reaches similar conclusions, whilst also contrasting the process of professionalisation with its vocationalist past. He describes the gender-typed model of the religious 'sister', based on the nurse's supposed dedication – a form of religious 'mission' – and a realisation of what was considered the 'innate maternal instinct' of women.

Davies (1995) also frames her discussion of the 'professional predicament' in nursing in terms of existing definitions, institutional structures and the subordination of nursing to medicine. Her principal contention is that nursing has become 'the work that medicine

rejects or fails to see' (p. 90), comprising a heterogeneous range of tasks which are themselves routinised and devalued. Davies suggests that the characteristic instability of the nursing workforce tends to reproduce over time a hierarchical organisation within nursing which is detrimental to professional development, as this is based on the giving and following of orders. Even relatively more powerful nurses within this hierarchy experience a downgrading of their expertise, as the potential 'unity' of the nursing profession is ruptured by the emphasis on routinised tasks. However, it is worth noting that even in Southern Italy, where the nursing workforce is extremely stable, with practically no rotation of staff and no agency nurses, and where more than three-quarters of nurses work the same shift system, the standardisation and routinisation of care is striking.

Davies, like many other writers on nursing, provides a rather idealist account of the development of nursing from its vocationalist roots towards 'professionalisation'. She highlights two alternative models of professionalism, based on the 'old professionalism' (which she associates with the medical profession) and the 'new professionalism', which represents a more appropriate future for nursing. Whilst the former is 'imbued with the mark of masculinity' (p. 134), the latter emphasises the contributions made by all members of the health care team and its responsibility to users of the service. This distinction between 'old' and 'new' forms of professionalism appears rather forced, however, imposing a monolithic view of the medical profession and foregrounding the role of gender differences in the composition of medicine and nursing (cf. Abbott & Wallace, 1990). In Naples, where almost two-thirds of nursing staff in the case-study hospitals are male, an even more marked situation of nursing subordination and exclusion from decision-making prevails. Male nurses in Italy are not concentrated in senior positions within nursing and there are no differences in the hours worked by male and female nurses. In more general terms, the word for nurse in Italian has a masculine and a feminine form (*infermiere/infermiera*), the former being used most often to refer to 'the nurse'. Given the long history of male nurses in Italy, it seems rather implausible to suggest that gender alone can account for the continued subordination of nursing in that country. Moreover, given the similarities between the grievances of Italian and Irish nurses in this regard, it is possible to argue that other factors are more important.

To return to the 'new professionalism', it is also evident that this area of the nursing research literature incorporates a strongly subjectivist strand which is highly problematic in its own right. It equates the 'medical model' with 'scientific rationality', which is then linked with male dominance, drawing on an influential strand within feminist theory. Other forms of knowledge are contrasted with this 'scientific rationality', including religious beliefs and mysticism (c.f. Schön, for example). Davies does not explicitly accept this standpoint, but nevertheless links 'science' with 'the cultural baggage of masculinity' (p. 151) and imbues the concept of 'caring' with metaphysical overtones.

Many contributors to this body of nursing research have a tendency to abstract from power relations within the workplace, minimising the role of government policy and general management in shaping the hospital division of labour. Thus, the fact that Junior Doctors also occupy a subordinate role under the direction of Senior Consultants is not considered. Similarly, the distinctions within the nursing profession between nurse managers, on the one hand, and ward nursing staff, on the other, is downplayed. These complexities have no place in the homogeneous picture of the nursing profession provided by these authors: nurses are depicted as engaged in a struggle which will take them from their 'vocationalist' past towards a 'professionalised' future, in a linear evolutionary process.

Bellaby and Oribabor (1980) challenge 'unitary' visions of the development of nursing, pointing out that in Britain in the early part of the century it was by no means the case that all nurses shared a vocationalist outlook with the religious orders. In fact, the late 1930s were marked by a rapid growth in union membership, enough to be seen as a threat by the leadership of the professional associations. For example, in 1937 the Royal College of Nurses opposed a parliamentary bill which would have provided hospital employees with a fixed working week, and a confrontation opened up between the Trades Union Congress and the RCN, which refused membership to male nurses, students and nurses on the supplementary registers (Bellaby & Oribabor, 1980: 157).

Bellaby and Oribabor explain nurses' professional grievances by referring to the division of labour brought about by the expansion of nursing during its 'second phase' (which corresponds roughly to the inter-war years), and the development of a training system which forced student nurses and unqualified staff to do much of the basic work on the wards. Although there are problems with Bellaby and Oribabor's account (it is no longer the case in either Ireland or Italy that unqualified staff constitute the majority of the nursing workforce), they nevertheless identify an important issue. The attempt by advocates of nursing professionalisation to boost the status of nursing tends to relegate day-to-day nursing care to less qualified staff, giving rise to a stratification which cuts against the aim of working as semi-autonomous practitioners within a multidisciplinary care team. Rather than being 'set free' as professionals, qualified nurses would spend more and more of their time supervising less qualified staff and carrying out administrative and managerial tasks. Moreover, with the introduction of managerialism, the promise of career progress is revealed to be largely illusory. For example, the new 'promotional grades' introduced in Ireland following the publication of the Report of the Commission on Nursing involve only a tiny fraction of the nursing workforce.

The advocates of professionalisation strategies in nursing are evidently aware that the models of nursing that they are advocating will create 'losers' within the nursing workforce. However, they tacitly accept that given the number of nurses currently working in the health service, they are unlikely to obtain the levels of autonomy, status and remuneration that they desire if these must be extended to the workforce as a whole. For example, in Ireland, no opposition was voiced when, in the context of the introduction of the new degree programme for nursing, a lower-paid, largely unqualified category was created, ostensibly to replace first-year nursing students:

> *I suppose I have been thinking about it for a number of years and probably have shifted from not liking it at all to thinking this is logical, reasonable to a certain extent. [Researcher: On cost grounds?] On cost grounds, exactly, as nurses' salaries go up, it is. And also on the grounds of what nurses and Ward Attendants could potentially be doing. I don't think you need a nurse to make an empty bed. ... In the area of skill mix and so on, bringing in things like Ward Attendants, I have detected a degree of ambiguity at the level of the representative associations – the INO and so on, and An Bórd Altranais (the regulatory body for nursing in*

Ireland) – have quite often seen these kinds of changes as possible facilitating a shift in nurses' role. I mean, given the sort of priorities attached to professionalisation, some nursing representatives have said that "nurses cannot be professional if what they are doing is making beds, and so on, tasks which any seventeen year-old with a week's training could do".[126]

In Italy, the advocates of nursing professionalisation are associated primarily with the College of Nursing, referred to as *IPASVI*, which incorporates *Assistenti Sociali* and *Vigilatrici d'Infanzia* alongside *Infermieri Professionali*. Michela Rizzello, President of the *Collegio IPASVI* in Campania, underlines the importance of the shift to the University degree course, in-service training, an autonomous nursing management structure and representation of the nursing profession at parliamentary level. Rizzello, in common with many nursing representatives, is particularly critical of nurses who fall short of the required standards, criticising in particular the *disoccupati organizzati* (members of the movement of the 'organised unemployed') who entered the health service in Naples in the mid-1970s at the crest of a protest movement:

The famous 'organised unemployed': no motivation, limited abilities, some of them – those who went through the conversion process, the famous 'generic nurses' who did one year. ... 90 per cent of them acted as a brake on the development of the profession and encouraged all of those behaviours to which they were accustomed, as people who had been in the middle of the street, as 'organised unemployed'...[127]

Rizzello is also in favour of a privatised, contractual model of nursing care, involving the formation of nursing co-operatives which would bid for contracts within the public health service:

... we believe that the future of nursing lies with the private rather than the public sector, and private contracts even within the public system. ... But we need to encourage a new mentality within the nursing category, which is completely out of tune with this. Always used to working for a wage, institutionalised... Private

[126] Female Unit Nursing Officer (42 years of age) in *Voluntary Hospital*, Interview 1-1.
[127] Michela Rizzello, President of the IPASVI in Campania, Interview P-1.

work carries with it considerable responsibilities, because you have to draw on your own resources when dealing with the client.[128]

The *Collegi IPASVI*, like the nursing researchers discussed earlier, espouse a version of the 'professionalisation' project, and have been heavily influenced by the publications of American and British researchers and professional representatives. As Haiven (1996) points out, however, professionalisation is primarily a strategy to consolidate the labour market power of skilled workers. Nursing representatives – like advocates of medical professionalisation during the Nineteenth Century – have sought to justify their labour market strategy in terms of its benefits for patients. Nevertheless, it is apparent that the changes sought primarily benefit nurses – and only some nurses at that.

These criticisms of the professionalisation project do not imply that nurses and nursing researchers should not seek to augment their skills, understanding and capacities. What is questioned is the *labour market strategy* linked with this project. By encouraging nurses to organise separately from other health workers and to avoid identifying themselves with less skilled occupational groups, the advocates of professionalisation have arguably weakened the position of nurses. Given the difficulties involved in taking effective strike action in the health service, the wider union movement is a crucial ally for nurses. As I showed in Chapters Two and Four, minimising costs and maximising productivity are central to the current rationalisation of healthcare in Ireland and Italy, and management appears to view the future of nursing in a different light to the 'professionalisers':

I will just reiterate the point: the CORE job of nursing is still hands-on nursing. If you go into a hospital and observe nurses in action, what are they doing? I mean they're not all sitting monitoring high-tech equipment. You know, there's a lot of the job there that by definition cannot change. It can't fundamentally change if nurses are to provide the type of service that they've provided over the years. Unless we're going to get somebody else to do that. In which case there are going to be an awful lot less nurses.[129]

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[128] Michela Rizzello, Interview P-1.
[129] Gerard Barry, Interview M-4.

Quality of Care, Shortage of Materials

I will turn now to the fourth family of grievances, which includes issues relating to the quality of patient care. It might be argued that these kinds of concerns do not qualify as 'grievances' as they are not specific to nurses and they are not related to their conditions of employment. However, they are rooted within the hospital labour process, they give rise to anger amongst nurses and have a strong influence on how nurses relate to their unions. For these reasons alone, they deserve to be included in any discussion of nurses' work grievances. What appears to happen, in fact, is that nurses adopt *patients'* grievances as if they were their own. There is nothing particularly surprising about this, given the nature of the relationship between nurses and their patients and the link between the well-being of patients and the satisfaction and self-realisation of nurses.

Table 5.13 Grievances of Irish Nurses Regarding Patient Care

Extract No.	Hosp. No.	Age	M/F	Extract
69.	No. 1	28	F	*Stretchers put everybody out: they put the patients in the room out, they put the person that is going into the stretcher out. To us, nursing-wise it doesn't really make that much of a difference ...*
70.	No. 1	42	F	*another big problem in Recovery then is, you know when we're trying to control pain afterwards. ... So that sometimes ... you could spend half an hour walking up and down the corridor looking for somebody*
71.	No. 1	31/ 33	F/ F	*[Is it harder to take care of patients if they are not in a proper bed?] First Interviewee: Yeah, much harder. You have no light switch, if they are on drips you have no sockets, and trying to squeeze their locker in. Second Interviewee: There is no room for equipment at all*
72.	No. 1	31	F	*... and the patients might say to you ... "we are paying VHI" ... and "why this". And you are doing your best – and you DO do your best – but they are not happy with that*[130]
73.	No. 1	42	F	*... we do a lot of patients from the private hospital and if they've two patients and only one patient can be done, it's usually only the public patient that's cancelled. And that's another form of bullying ...*[131]

[130] The interviewee in this extract is the same as the first interviewee in the preceding extract.
[131] The interviewee in this extract is the same as in Extract No. 79.

Table 5.14 Grievances of Italian Nurses Regarding Patient Care

Extract No.	Hosp. No.	Age	M/F	Extract
74.	No. 2	42	M	*We are getting by with beds which date back to 1930! Have you any idea what that means: 67-70 years ago, when this hospital was built by Benito Mussolini! Look at the stretcher-bed that we have for consultations. It took five years to get two new desks ...*
75.	No. 2	48	M	*... I can only give the patient the time necessary for administering the medication. In other words, I can't talk to him/her, I can't sit down next to the patient in order to discuss things or to try to help him/her*
76.	No. 2	48	M	*We even have to make up extension leads in order to monitor patients, in order to use an injection pump. At times you have to literally invent things, even in violation of the law ...*[132]
77.	No. 2	39	M	*... we have a box room, where we have some patients who should be in Intensive Care – we have to keep them in the ward, even though they are patients who should be monitored 24 hours a day ...*
78.	No. 2	43	M	*For example, we still use oxygen canisters, which we have to carry around with the patient ... They still haven't installed a centralised system, despite all the dangers associated with keeping these enormous canisters by the patient's bedside*
79.	No. 3	53	M	*Orthopaedic patients in traction should be moved, massaged and washed more often than we can manage*
80.	No. 3	41	M	*... most of the time we have two or three stretcher-beds ... By now, they have become a permanent fixture ... I mean the idea of having a patient who has suffered a stroke lying on a stretcher in the corridor, even the idea strikes me as absurd*

Although Irish nurses are by no means fully satisfied with the equipment at their disposal, they appear to be more concerned about overcrowding and unequal access to care than their Italian counterparts. As I pointed out in Chapter Two, the two-tier system in operation in Ireland is highly inequitable:

[132] The interviewee in this extract is the same as in the previous extract.

> *I think myself that some kind of sense of standards have got to be set in relation to waiting lists. People have to look at what happens in a private ward or in a semi-private ward and how come somebody who has VHI cover for the Blackrock clinic can get anything from a transplant to a bypass virtually on demand, and delete the word virtually: almost immediately.*[133]

As I mentioned earlier, the 'therapeutic relationship' between nurses and their patients underlies nurses' commitment to the resolution of issues such as the above. Nurses sometimes explain this commitment in terms of 'social reciprocity' (i.e. their duty towards other individuals who themselves contribute in various ways to the collectivity), pointing out that a relative of theirs could easily be the next person in the hospital bed. The existence of a strong link between nurses and their patients is a specificity of nursing, and distinguishes this from many other occupations: the job of being a nurse involves entering into emotional relationships with patients. In doing so, nurses often develop a sense of responsibility for their patients and experience feelings of affection or empathy. This can be a source of satisfaction, just as it can fuel intense frustration when obstacles to patient care present themselves. The following extract, from an interview with a Psychiatric Nurse, provides a powerful example:

> *... we had even an incident last Friday evening – we had a patient who was very very depressed went missing off the ward from half one until half four and I was... I mean I was nearly physically sick because I was sure that this woman would be found thrown up on Sandymount strand or something. And I couldn't go off duty until I knew what had happened to the patient, so I had to stay. And it was 5 o'clock, when I should really have been finished at three. And then she came back and that was it, and you go home and you're left with no way to discharge that or to ventilate the feelings.*[134]

The interview material (see Tables 5.13 and 5.14) suggests that patient care grievances are much more strongly associated with the absence of materials and equipment in Italy; indeed, numerous extracts could be provided to illustrate the difficulties created by the

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[133] Kevin O'Driscoll, Interview U-8.
[134] Female Psychiatric Nurse and Ward Sister (33 years of age) in *Voluntary Hospital*, Interview 1-7.

shortage of everything from antibiotics to bandages. For Neapolitan nurses, the ability to 'make the best of a bad situation', and to invent solutions to these problems (*arrangiarsi*) is a source of pride, but they themselves are aware of the price that their patients pay for this, in terms of the risks to which they are exposed. Despite these shortcomings, the most important cause of patient care grievances for the Italian nurses is the chronic shortage of staff in the Neapolitan hospitals, and grievances relating to staff shortages and the quality of patient care often overlap in nurses' accounts.

Statistical Analysis of Survey Data

Before addressing the remaining four families of grievance, I will present the results of a statistical analysis of survey data on nurses' grievances in Ireland and Italy. In the questionnaire, nurses were asked to rate twelve potential grievances on a seven-point scale (these were pensions, retirement age, workloads, staffing levels, shift organisation, hours worked, quality of care, availability of resources, pay levels, possibility of promotion, access to training and degree of work autonomy). Figures 5.3 and 5.4 (earlier in this chapter) provide an indication of how nurses view these issues. In order to assess the inter-relationships between these grievances, I carried out an Exploratory Factor Analysis using the *SPSS* software. Prior to the analysis, I dropped all cases where more than one-quarter of items were missing and imputed all remaining missing values[135]. All twelve variables were submitted to a Maximum Likelihood Exploratory Factor Analysis and an oblique rotation was used (Oblimin) as factors expressing different dimensions were expected to be correlated. Separate analyses were initially carried out using the Irish and Italian data, but due to the close similarities between the results of these analyses (see below), all data were subsequently pooled.

The Kaiser-Meyer-Olkin measure of sampling adequacy for the pooled data is 0.81 (a highly satisfactory value) and the communalities range between .210 (quality of care) and .510 (pensions). The overall sample size is 831 and all variables have seven response categories. In each of the analyses (i.e. using pooled data and analysing Irish

[135] I used the EM (Expectation Maximisation) algorithm to impute 110 missing values (there were almost 10,000 responses: 831 nurses answered 12 questions) using responses to other question items as the predictor variables. No variable had more than 2.2 per cent missing and the estimated scores were without exception within the range of the response categories. Schafer (1999) shows that the imputation of missing data is preferable to deletion or substitution by the mean or modal value.

and Italian nurses separately), only three eigenvalues exceed a value of one, and these account for 56.7 per cent of the total variance in the 'pooled' dataset. The Pattern Matrix resulting from this analysis is provided below (Table 5.15), omitting values under 0.3 for ease of interpretation[136]:

Table 5.15 Pattern Matrix for Factor Analysis of Pooled Grievances Data

	Pooled Data		
Item	Factor One	Factor Two	Factor Three
Pensions	***1.00***		
Retirement Age	***0.62***		
Workloads		***0.71***	
Understaffing		***0.68***	
Shift Organisation		***0.59***	
Hours Worked		***0.54***	
Quality of Care		*0.46*	
Lack of Resources		*0.38*	
Pay Levels		*0.30*	
Promotions			***0.76***
Access to Training			***0.76***
Lack of Autonomy			***0.54***

The first factor is strongly related to pension levels and retirement age (I will refer to this factor as *retirement*), whereas the second is linked with workloads, staff shortages, shift organisation and working hours (I will refer to this factor as *working conditions*). Issues relating to the quality of patient care, resources for care and pay levels are also linked with this factor. Arguably, the second factor expresses the effects of resource shortages on staffing levels and patient care, and indicates that higher levels of concern over these issues are also associated with grievances about wages. Finally, the third factor is associated with promotions, access to training and work autonomy, and may therefore be identified with *professional advancement*. There is a correlation of 0.40 between *retirement* and *working conditions*, of 0.37 between *retirement* and

[136] The value of the chi-square statistic for the pooled factor model is 154 (33 degrees of freedom). Although this is rather high, it must be interpreted in the context of the relatively large sample size used.

professional advancement and 0.39 between *working conditions* and *professional advancement*.

Separate analyses carried out using the Irish and Italian samples confirm the similarities between the outlook of Irish and Italian nurses as far as work grievances are concerned. This is a striking result, given the differences in gender composition, age profile, family situation, social class origins and labour market situation between nurses in Dublin and Naples. Table 5.16 below compares the Pattern Matrix for the two samples when separate factor analyses are carried out, again omitting loadings under 0.30.

Table 5.16 Pattern Matrix for Separate Factor Analyses of Grievances Data

	Ireland			Italy		
Item	Factor One	Factor Two	Factor Three	Factor One	Factor Two	Factor Three
Pensions	***1.00***			***0.87***		
Retirement Age	***0.58***			***0.76***		
Workloads		***0.86***			***0.55***	
Understaffing		***0.77***			***0.64***	
Shift Organisation		*0.43*	*0.39*		***0.67***	
Hours Worked		*0.43*			***0.63***	
Quality of Care		***0.59***			*0.47*	
Lack of Resources		*0.34*	*0.32*		*0.34*	
Pay Levels			*0.35*		*0.37*	
Promotions			***0.74***			***0.78***
Access to Training			***0.73***			***0.75***
Lack of Autonomy			***0.61***			***0.58***

Table 5.16 reveals striking similarities in the ways in which Irish and Italian nurses rate their work grievances, generating a clear and highly-interpretable three-factor solution with very similar loadings. The contrasts between the two samples are also interesting, however, as they identify salient differences in the situation of nurses in these two countries. Firstly, pay issues are linked primarily with *professional advancement* in Ireland, but with *working conditions* in Italy. This corresponds to the emphasis placed

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Hu & Bentler (1999) demonstrate that the chi-square statistic is dependent upon sample size, and small

on incentives for professional qualifications in Ireland in the context of the nurses' pay campaign (1996-1999) and the more traditional 'employee' orientation of the Italian nurses. In the Italian case study hospitals wage issues seem to be evaluated in relation to the 'wage-effort bargain', whilst in the Irish hospital, wages are evaluated in the context of 'professional qualifications' and 'work autonomy'.

Secondly, shift organisation and working hours are more strongly associated with *working conditions* in Italy than in Ireland, perhaps reflecting the reliance of the Italian hospitals on overtime and double shifts in order to maintain staffing levels. Finally, shift organisation and lack of resources have cross-loadings on *professional advancement* in Ireland but not in Italy, suggesting that nurses who are concerned about the lack of access to training, promotion prospects and lack of autonomy are also more likely to view shift organisation and resource availability in negative terms. It is therefore likely that these 'professionally-oriented' nurses have higher aspirations in relation to the management of nursing staff and the availability of materials and facilities.

The factor analysis model estimated with the pooled dataset was used to generate factor scores in order to evaluate age, gender and cross-national differences in relation to grievances[137]. Tables 5.17 and 5.18 below present the mean factor scores for Irish and Italian nurses on each dimension broken down by gender and age group. As the factor scores have a grand mean of zero and a standard deviation of one, the values in the table have a straightforward interpretation: a value of 0.5 for the *retirement* factor, for example, would indicate that the group in question is more aggrieved about pension levels and retirement age than nurses in the sample as a whole and that their mean score differs from the overall mean by half a standard deviation unit.

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discrepancies in model fit are therefore 'magnified' when large samples are used.

[137] I carried out a Reliability Analysis to evaluate the acceptability of these scales. Coefficient alpha for the two variables that load strongly on the *retirement* factor is 0.79, for the variables most strongly linked with *working conditions* 0.76 and for those associated with *professional advancement* 0.74. These values are highly satisfactory.

Table 5.17 Composite Indices of Nurses' Work Grievances by Gender

Scale	Ireland			Italy		
	Female	Male	Total	Female	Male	Total
Retirement	*-0.22*	*0.52*	*-0.21*	*0.30*	*0.13*	*0.18*
Working Conditions	*-0.07*	*0.38*	*-0.07*	*0.20*	*0.04*	*0.09*
Professional Advancement	*-0.24*	*0.70*	*-0.22*	*0.21*	*-0.20*	*0.20*
Sample Size	*253*	*4*	*258*	*151*	*330*	*493*

Table 5.17 shows that Italian nurses rate all three types of grievance at a higher level than their Irish counterparts and express much greater concern about *retirement* and *professional advancement*. Given the small number of male nurses in the Irish sample it would be inappropriate to generalise from Table 5.17, but male nurses in Italy are less concerned about *retirement* and *working conditions* and much less concerned about *professional advancement*.

Table 5.18 Composite Indices of Nurses' Work Grievances by Age

Scale	Ireland				Italy			
	<30	30-39	40-49	50+	<30	30-39	40-49	50+
Retirement	*0.26*	*0.12*	*0.22*	*0.32*	*0.09*	*).23*	*).24*	*0.05*
Working Conditions	*0.05*	*0.06*	*0.06*	*0.18*	*).58*	*).24*	*).00*	*0.12*
Professional Advancement	*0.18*	*0.13*	*0.63*	*0.73*	*).12*	*).22*	*).22*	*).10*
Sample Size	*142*	*76*	*21*	*12*	*20*	*153*	*214*	*82*

Table 5.18 shows that concerns about *retirement* are particularly high amongst Italian nurses aged 30-49 and that the importance of these issues is a little lower amongst nurses aged 50 years and over in both countries. This is likely to reflect a cohort effect, as nurses aged over 50 often have a relatively 'vocationalist' orientation towards nursing. As far as working conditions are concerned, a distinct decline in grievances is observed amongst older nurses in both countries, with younger nurses rating these

issues more highly than older nurses. Although there are only 20 nurses under 30 years of age in the Italian sample, these nurses express very high levels of dissatisfaction in relation to working conditions (i.e. workloads, understaffing, shift organisation, quality of care etc.). In Ireland, anger at the difficulties involved in obtaining professional advancement is highest amongst nurses aged between 30 and 39 years and tends to decrease with age. A similar pattern is observed in Italy, although the severity of this issue is rated much more highly than in Ireland and there is only a small decline in the responses of nurses over 50 years of age.

I also estimated three statistical models with the aim of exploring the relationship between grievances, on the one hand, and variables such as age, gender, marital status and ward type. I will begin by presenting the results of the first model, in which *retirement* was the dependent variable. The following variables were entered into the Multiple Regression model: country (Italy; Ireland), age (years), gender (female; male), marital status (single, divorced, widowed; married), children (none; at least one), employment grade (Staff Nurse; Ward Sister/Nurse Manager), employment status (full-time; temporary/agency/substitute), ward type (General Medical/Surgical ward; Operating Theatre/A&E), experience of nursing (months), working hours (average per week), union membership (non-member; member), attitudinal militancy (scale) and vocational orientation (scale)[138]. After taking account of missing data, the overall sample size was 784.

Variables that were not statistically significant at the 0.10 level were excluded sequentially in order to obtain a parsimonious and robust model. The only variables with a significant effect on *retirement* are having children (with a standardised regression coefficient of 0.18) and the type of ward in which one works (0.12). The explanatory power of the model is weak with an adjusted R^2 of just 0.05, implying that it explains just 5 per cent of the variance of the *retirement* factor scores (both effects were nevertheless statistically significant at the .001 level). Thus, nurses working in Operating Theatres and A&E Departments and those with children tend to rate the issue of pensions and retirement age as more serious than other nurses. The first effect is most

[138] The measure of 'militancy' is a composite scale based on responses to questions 25, 29 and 33 (see the copy of the questionnaire included in Appendix A and see discussion of orientations in Chapter Six), and the measure of 'vocationalism' is based on responses to questions 26, 28 and 32.

likely due to the greater intensity of work in these areas, whereas the second may be related to the larger financial outgoings of nurses who have formed a family, or indeed to their aspirations in relation to early retirement.

Turning now to the second model, in which *working conditions* is the dependent variable, a more complex picture emerges. The strongest effect is associated with ward type (the standardised regression coefficient is 0.19), followed by working hours (0.14), employment status (-0.09) and 'vocationalism' (-0.07). All of these effects are statistically significant at the 0.05 level and the adjusted R^2 for the model is 0.07; after accounting for missing data the sample size is 779. Thus, nurses working in Operating Theatres or Accident & Emergency Departments and those who work longer hours tend to rate grievances related to *working conditions* as more serious than other nurses. Those on temporary contracts and those with a 'vocationalist' attitude towards nursing tend to view these issues as being less urgent[139]. Once again, it is striking that no statistically significant effects associated with national context, age, gender, marital status or employment grade were detected.

The third model regresses *professional advancement* on the same pool of independent variables used in the previous two models (the overall sample size, after taking account of missing data, is 775). Six variables have a statistically significant effect on *professional advancement* grievances, and the overall model has an adjusted R^2 of 0.10. The strongest effect is associated with country (standardised regression coefficient of -0.20), followed by ward type (0.12), working hours (0.11), employment status (-0.10), 'vocationalism' (-0.10) and employment grade (-0.08). Thus, nurses working in Operating Theatres or Accident & Emergency Departments are more likely to be concerned about *professional advancement* than those working in other areas, and this also applies to nurses who work longer hours. Unsurprisingly, Ward Sisters and Nurse Managers are less likely to have grievances in relation to promotions, training and autonomy, and this also applies to temporary and agency staff. Italian nurses tend to rate these issues as more serious than their Italian counterparts (controlling for the other

[139] 'Vocationalism' is defined here in terms of the motivation for becoming a nurse ('I decided to become a nurse because I wanted to help the sick and injured'; 'I (did not decide) to become a nurse for economic/employment reasons) and attitude towards industrial action ('A nurse should not take industrial action which may have a negative impact on patient care').

variables in the model) and nurses with a stronger vocationalist orientation tend to view them as less serious.

To summarise this section, the survey results confirm the strong similarities that exist between Irish and Italian nurses in relation to work grievances. Moreover, the results of the statistical models indicate that relatively structured features of nurses' employment situation – such as the type of ward in which they work, their employment status and working hours – have a stronger influence on their ratings of grievances than characteristics such as gender, marital status and age. I will return now to the qualitative analysis of nurses' grievances in relation to health and safety issues, facilities for nursing staff, work relationships and self-realisation.

Health and Safety Grievances

Although it is difficult to identify the precise origins and extent of health and safety risks, nurses themselves are aware that they are continually exposed to avoidable risks. In fact, hospital nursing poses a number of health risks which are difficult and costly to avoid: (a) stress, physical and emotional exhaustion and 'burnout', (b) chemical, pharmacological, bacterial and other exposure-related risks and (c) the danger of physical assault, accidents or injury. Table 5.19 below summarises the interview evidence for each of these four types of grievance

Table 5.19 Grievances of Nurses Regarding Health and Safety Issues

Extract No.	Hosp. No.	Age	M/F	Extract
				Stress & Emotional Burnout
81.	No. 1	25	F	*But I do see people and people think "Oh God, that relative is such a pain". But they forget that they've just been told that their mother has six months to live and this is their way of dealing with it. And it can be very stressful, you have to know what way to take it*
82.	No. 2	42	M	*To witness death is certainly not good for the health – we look after people who are dying. And we see our own relatives again and again in the deaths of others ...*
83.	No. 3	37	M	*You know that in Intensive Care we encounter burnout ... we are shut for the duration of the shift into a kind of bunker ... We are frequently assaulted by patients' relatives. We often have police in the corridors because we have patients who have been shot and so on*

Table 5.19 *Continued*

Extract No.	Hosp. No.	Age	M/F	Extract
				Exposure to Environmental Pathogens
84.	No. 2	34	F	*... this being an infectious disease unit ... We should ideally enter the ward in uniform. But there are no changing-rooms, so we come in wearing our own clothes. ... On our way home, we should have the possibility of taking a shower ... All of this, unfortunately, is lacking*
85.	No. 2	36	M	*... another major risk factor is exposure to X-rays, because in order to implant a pacemaker, you have to insert a catheter into a vein and this catheter has to be followed as far as the heart, to permit its precise positioning, with the help of various pieces of imaging equipment ...*
86.	No. 3	31	F	*... we have Operating Theatres which do not conform to EC laws, they are disgraceful, basically there are gas leaks – the anaesthetic gases accumulate within the Theatre itself. ... In fact, one of our Anaesthetists contracted Hepatitis C*
87.	No. 4	48	M	*In order to prepare the chemotherapy drugs – which are particularly harmful to the patient, but also for those who handle them. There have been cases of nurses who have got Leukaemia or tumours ... with fume cupboards, you can reduce this risk ... but we don't have any*
				Accidents, Assaults & Injuries
88.	No. 3	53	M	*... here all our patients are immobilised ... So you need a considerable amount of physical strength. I have been operated on, and I need a back support so that I can continue working even with a slipped disk...*
89.	No. 3	36	M	*[how did you get this injury?] I got it while washing an instrument. But, for example, there are heaps of irregularities here. For example, there are loads of cables lying on the ground – I could trip on them*

As I noted in the preceding section, nurses are forced to bear a considerable emotional and psychological burden in carryout out their responsibilities. Dealing with sick patients in conditions of staff shortages and heavy workloads is stressful and there is great pressure on individual nurses to maintain high standards of nursing care. The emotional distress experienced by nurses following the death of their patients can be severe – particularly in the absence of adequate counselling services – and the sense of guilt and responsibility provoked by their inability to prevent undesirable outcomes are

damaging to their psychological well-being. In certain areas of nursing work, a stress-related syndrome known as 'professional burnout' is observed. The primary symptoms are emotional withdrawal, loss of concentration as well as sleep and behavioural disturbances. In areas of high patient dependency, isolation from the outside world, artificial lighting, high workloads and emotional stress – Intensive Care and Coronary Care Units, for example – nurses can be particularly prone to burnout (Schaufeli, Maslach & Marek, 1993).

It is interesting to note that awareness of the health risks found within the hospital environment is growing rapidly amongst Italian nurses, and has already given rise to numerous *ad hoc* coalitions of nurses who, at local level, seek to raise their colleagues' awareness of these issues. For example, in the fourth case study hospital (which I refer to as *Emergency Block*, as fieldwork was confined to the Accident and Emergency Department), a group of nurses in the *Rifondazione Comunista* political party set up a free-sheet to distribute within the hospital with the aim of improving the quality of care and eliminating avoidable health risks. In Naples, it is apparent that the unions have made little attempt to secure improvements for their members in relation to health and safety issues, and several nurses mounted strong criticism of this phenomenon.

Table 5.19 contains just one extract from *Voluntary Hospital* (the Irish case study hospital), as I have already discussed some of the emotional and psychological risks identified by Irish nurses and because hospital management has taken a much more pro-active stance in this hospital, conducting training on health and safety issues and taking steps to minimise occupational hazards (with regular monitoring of needle-stick injuries, the installation of fume cupboards and policies on lifting patients). Naturally, this has not eliminated health risks (this is most likely impossible), but has reduced their pertinence for nurses, who are more likely to express concern about other issues. Moreover, the young average age of the Irish sample means that these nurses may not yet have encountered the health problems that older nurses tend to experience.

As I suggested at the beginning of this chapter, the main reason for the persistence of health risks within the hospital environment is the cost of converting existing hospitals so that they conform to recent legislation. Given the age of many Neapolitan hospitals

(and the technical incompetence of many hospital managers), it is unsurprising that health and safety grievances should be particularly pronounced in the Italian sample. Despite the availability of funding from central government in Italy for the modernisation of the hospital infrastructure (what is known as the *ex-articolo 20*), there have been inexplicable delays in the formulation of development plans. As I noted in Chapter Three, however, the new management team which arrived in *Azienda* in the mid-1990s focused primarily on this issue, creating a precedent for the other metropolitan hospitals. As the deadline for the utilisation of this funding approached at the end of the 1990s, a number of other hospitals presented plans and began to undertake renovation work. Given the nature of the existing hospitals (many of which date back to the Nineteenth Century or earlier), and the numerous problems with the development plans (which are often not in conformity with the law number 626), this work is unlikely to resolve the health and safety grievances described above.

Facilities for Nursing Staff

The sixth family of grievances relates to the lack of facilities for nursing staff. Although problems regarding changing-rooms, uniforms and chairs may appear rather mundane in comparison with the issues discussed in previous sections, it would be a mistake to underestimate the importance of this category of grievance, not only because they have a major impact on nurses' subjective experience of work, but also because of their 'symbolic' significance.

In the context of a highly stressful work environment, it is understandable that the availability of a space within the ward in which nurses can rest in moments of relative calm and prepare themselves for their next intervention should assume importance. Changing-rooms also have an almost symbolic quality for nurses: they are where you prepare yourself to assume the role of the nurse at the beginning of a shift and where you express your frustrations and satisfactions at the end of the day. Changing-rooms are also a point of congregation and socialisation, a space in which opinions and beliefs are exchanged. This is why I suggested at the beginning of the chapter that they are a

fruitful location for social observation[140]. It is significant in this context that the impetus for an initiative in *Presidio* to renew local union structures began in the changing-room (see Chapter Six). The sensation of being treated with little respect goes beyond the mere absence of soap and towels from changing-rooms. Moreover, the failure of hospital management in Naples to provide decent uniforms infuriates nurses, as it is interpreted as a sign of managers' lack of respect for their professionalism. Similarly, the fact that Irish nurses are typically forced to purchase their own uniforms – which must conform exactly to the specifications provided by management – is also a source of anger. Table 5.20 below summarises the evidence from the interviews in relation to this category of grievance.

It is important to maintain a broad perspective when analysing work grievances, and it is therefore interesting to note (Extract No. 95) how the absence of crèche facilities for hospital employees, in the context of a public kindergarten/school system with severe limitations can create difficulties for nurses – female nurses in particular.

[140] It is obviously important to recognise the gendered nature of this space, as the separation of male and female nurses implies relatively distinct processes of socialisation and social exchange.

Table 5.20 Grievances Regarding Facilities for Nurses

Extract No.	Hosp. No.	Age	M/F	Extract
90.	No. 1	25	F	*[... they (the male nurses) didn't want the uniform they were given?] Because they never, they didn't get to see it beforehand and they just didn't like the colour and they thought it very feminine, which it is. They're dreadful uniforms*
91.	No. 1	31/ 33	F/ F	*[How much are your uniforms?] First Interviewee: £30 for a top, £30 for a trousers. So that's £60. Second Interviewee: And you need about 3 sets. First Interviewee: And your shoes, your cardigan, you know. And it wouldn't even be an issue that the hospital would ever finance them*
92.	No. 2	42/ 42	M/ F	*First Interviewee: Our room is on a veranda, with a glass partition. This winter I reported it, because big lumps of plaster were coming down. Second Interviewee: We have no space of our own. ... A decent changing-room. We need a decent changing-room, we have nowhere where we can rest for ten minutes, five minutes*
93.	No. 3	34	M	*We have very little space – what with cupboards, lockers, table, desk - where nurses can stay at night. The fact that we don't have even the most basic facilities for resting during the night – I don't know, an armchair, a foot-rest – is really serious*
94.	No. 3	37	M	*... even considering only the changing-room here in the hospital that I showed you, and the precarious conditions – not only in terms of hygiene but also ... our social relationships ... It impoverishes you, I don't know, even culturally*
95.	No. 3	31	F	*I went to pick up my child at school, in the afternoon, and I found him asleep on a bench – it's a private school. The working woman receives absolutely no help – nothing, nothing. If you don't have a mother, a granny, an aunt, then you have to make do and look for a baby-sitter – and then you don't know who you are letting into your home*

Bullying and Interpersonal Conflict

The penultimate category of work grievance relates to the relationships (a) between nurses themselves, (b) between nurses and other members of the multidisciplinary care team, (c) between nurses and managers and (d) between nurses and their patients. As noted at the beginning of this chapter, nurses generally aspire towards non-oppressive relationships with their colleagues at work and cooperative relationships with colleagues, doctors, porters, domestics, cleaning staff, technicians and other members of the care team are essential to the coordination of care.

In terms of the nurse-patient relationship, creating a 'therapeutic relationship' is conditional upon negotiation and consent. The constructive role of managers in coordinating and organising the disparate occupational groups and services within the hospital is negated if this is overlaid with an authoritarian approach. An overbearing management style tends to reduce the motivation of nurses and to interfere with the development of cooperative work relationships. Were nurses to follow the logic of such an authoritarian management style and to withdraw their willingness to go beyond their formal roles, it is clear that massive problems in the provision of hospital care would manifest themselves. Health service managers have taken advantage of nurses' goodwill in the context of declining staffing levels over the last ten years, and this has contributed to nurses' frustration and anger:

> *We got this today, right (picking up a piece of paper from the desk). So this is from my Chief Exec and what it says is "do more than your job". "Even though we know times are hard, a kind word, a sympathetic ear..." I could just vomit over this... "A helpful hand, a willing staff member prepared to go beyond what his or her job description states ..."*[141]

The relationship between doctors and nurses has received enormous attention within the 'nursing research' literature, as well as in feminist sociology and the sociology of the health service (Davies, 1995; Porter, 1995; Mackay, 1993; Salvage, 1985; Abbott & Wallace, 1990; Gamarnikow, 1978). Their relationship with medical staff is obviously

[141] Male nurse in *Voluntary Hospital*.

of crucial concern to nurses, as their roles are complementary and together they constitute the core of the multi-disciplinary care team. Nurses generally aspire towards an active role in decision-making about patient care as well as demanding the respect of other staff members. This is clearly a highly complex issue, subject to considerable variation according to context. However, it is evident that nearly all nurses – regardless of hospital or national context – find their current relationships with medical staff problematic in some way. Although Ward Sisters tend to be much more positive about their relationship with doctors, Staff Nurses often find their relationship with medical staff oppressive.

However, as I stressed earlier, it is also important to point out that the grievances expressed by nurses in relation to medical staff do not imply that co-operation and agreement are not observed. For example, in the Operating Theatre of the Irish case study hospital, a climate of mutual support and respect is readily observable between these two groups. During the nurses' pay campaign in 1997, nurses reported that they received support from their medical colleagues, who encouraged them to 'stick to their guns'. During the national nurses' strike in 1999, the Irish Medical Organisation declared its support for the aims of the strike and its members at local level insisted that they would not carry out nursing duties – unless in an emergency – in the nurses' absence.

Table 5.21 Grievances of Irish Nurses Regarding Work Relationships

Extract No.	Hosp. No.	Age	M/F	Extract
96.	No. 1	42	F	*On a Sunday morning the girls are supposed to start at nine and the Orthopaedics bully them and keep ringing them, you know, that they have to start at half eight. It's only half an hour but you know, it's just small little things like that. [To get more patients through is it?] Yeah*
97.	No. 1	28	F	*One of the wards I was working on WAS very quiet at the time, and like you would get to sit down and you'd be sitting there, chatting to one another ... While up here even when it is quiet you are expected to be seen to do some work [Yeah?]. Which I think is stupid*
98.	No. 1	32	F	*I heard it happened to a girl a few days ago, where she was being asked to work in a different – not asked, told – this is the thing you see, there's two different minds here, they don't see you as a (searches for the word) person. They see you as being employed by the hospital and they can send you anywhere that they want*

Table 5.21 provides an overview of the grievances of nurses in Dublin in relation to work relationships, and Table 5.22 summarises the evidence from the interviews with nurses in Naples. It is clear from these tables that grievances related to work relationships assume a different form in different hospitals. Oppressive relationships between nurses themselves is a major issue in Ireland, and has attracted considerable attention since the Commission on Nursing revealed the extent of 'bullying' within the nursing profession, often involving Ward Sisters or Nurse Managers. This forms part of the inherited occupational culture of nursing, and clearly cuts against the current aspirations of nurse representatives for autonomy and professional recognition:

> *I mean there was a culture in nursing that as a young nurse I mean it was part of your lot to be bullied by those in charge of you, you know. And I mean you do, you see it still in attitudes. You know, two people working together, obviously know each other – I mean they're from the same town or you know, the same location – one of them is let's say a Ward Sister or promoted or whatever, and they pass by and they say something like 'Staff, bring me this' (peremptory tone). I mean 'Staff' being short for 'Staff Nurse'. And you know you say to yourself 'why does she say Staff', why doesn't she say 'Mary, could you get me this' as you would anywhere*

else, you know. And you still see that kind of culture. But what was interesting was that the Matrons came into the Commission and the Commission put it to them that they detected a lot of demoralisation in staff and it seemed to them that a large part of it was down to what they described as bullying by people in authority and the Matrons agreed with it! Now they were the ones who were basically being pointed at.[142]

As Table 5.21 shows, echoes of this occupational culture were detected in the interviews carried out with Irish nurses. Although a number of dramatic changes have occurred in recent years, elements of this culture persist. This distinctive culture appears to be rooted in the attitudes and philosophy of the religious orders which own and run many of the acute hospitals in Ireland. In the past, ward nursing was directly controlled by members of religious orders:

So it was the nuns who were in charge in the (hospital) and it was more like a continuation of your school days, you know, you just did what the nuns told you. If they asked you to do something you know, you just didn't question it. Whereas the girls nowadays, student nurses and people who are doing the post grad courses and everything, they're much more aware of... their rights I suppose.[143]

This system of deference and control was actively reproduced for many years, and had a gendered dimension. Perhaps building on their relationships with family members, young female nurses were socialised to follow the orders of their superiors without questioning and were encouraged to internalise a 'vocational' ethic. The nature of Irish society facilitated the emergence of this occupational culture due to the dominant position of the Catholic Church and legislative provisions which largely excluded married women from full-time permanent employment. The 'marriage bar' was abolished in the 1960s, and the integration of married women into the labour force accelerated particularly during the 1980s.

[142] National union official in Ireland, 1997.
[143] Female Ward Sister (42 years of age) in *Voluntary Hospital*, Interview 1-9.

At the same time, the decline in the number of people joining religious orders forced the latter to rely on an increasingly 'lay' workforce, and nurse training reflected the developments within both nursing and medicine to emphasise the lay 'virtue' of professionalism. In a sense, the existence of an authoritarian management style within nursing only came to be identified as a *grievance* when social changes in the wider society provided nurses with the support they needed in order to stand up to the 'bullying' that they were experiencing.

Table 5.22 Grievances of Italian Nurses Regarding Work Relationships

Extract No.	Hosp. No.	Age	M/F	Extract
99.	No. 2	43	M	*... another idiocy invented by the Medical Director is to come and check whether nurses are awake. ... At night, as long as you are not working in Intensive Care, the nurse's job is also to watch and wait*
100	No. 2	42	F	*... I made a hundred applications for a transfer at the beginning. Six years ago I decided: 'That's enough! I can't keep this up'. I live in (a town outside Naples), and everybody from there has managed to get a transfer, but I have not, because I don't know the right people*
101	No. 2	49	M	*They even manage to convince you (colleagues who avoid work), they have a way with words. ... "What do you care about the Manager?" ... I am not interested in the Manager, I stay here so that I am ready if I am needed. If you leave, and something happens, how will I manage on my own?*
102	No. 3	53	M	*Unfortunately we have to pick up the burden for those people... The few people who still have a little personal integrity and good intentions end up overburdened. [How do the others get away with it?] I couldn't say. It's hard even to explain it, because everyone here has their own technique!*

In Italy – and in Naples in particular – the occupational culture of nursing is rather different, despite a number of similarities in terms of its historical development. For example, 'Professional' nursing was restricted to female nurses until the early 1970s and nurse training involved a similar socialisation process to that which occurred in Ireland. The Red Cross schools, in particular, were characterised by a strongly

'vocationalist' and religious orientation, and this ethos was reinforced by the role of the religious orders in staffing and running the hospital service.

During the mid-1970s, however, young unemployed people in Naples came together to form the movement of the *disoccupati organizzati* ('organised unemployed'). The unemployed demonstrators were organised into 'lists' – lists of people who were seeking work – and the aim of the movement was to force the local authorities to provide a job to all who were on these lists, avoiding a clientelistic approach to recruitment. Arguably because of the size of the movement (which at its height numbered more than 20,000), the Italian state eventually made concessions: thousands of unemployed youngsters were offered the possibility of entering the public services and public administration during the mid to late 1970s.

Because the health service was undergoing rapid expansion during this period, many of the unemployed demonstrators were forced to choose between a career in nursing and remaining out of work. This cemented the trend towards the entry of men into nursing (which had begun a few years earlier with the removal of the ban on male Professional Nurses, *Infermieri Professionali*). Many of the asylum attendants, porters and *Infermieri Generici* (a lower grade of nurse which was open to men) recruited during the previous period took advantage of the possibility of gaining entry to the more prestigious and remunerative category of *Infermiere Professionale*, and underwent conversion courses. After the establishment of the National Health Service in Italy in 1978, the expansion of the public hospital network encouraged large numbers of men as well as women to choose nursing, primarily due to the absence of alternative employment opportunities in the Neapolitan labour market.

Not only did the young unemployed marchers enter the hospitals as a cohort, on the back of a collective experience of struggle, they also brought with them the 'institutionalised' solidarity of the CGIL union and the Communist Party, which had supported their campaign. Given the absence of alternative employment opportunities, the difficulties involved in obtaining transfers and the stability of the shift system in the Italian hospitals, a very tightly-knit, highly-organised and assertive layer of nurses emerged. These nurses became accustomed to working with the same group of

colleagues and developed strong personal relationships within the hospital. Thus, it is very common for nurses working in the same ward and above all on the same shift to form strong personal friendships, and numerous married couples comprising nurses from the same hospital are to be found. These aspects of the social, political and cultural context in Ireland and Italy will play a key role in Chapter Six, where I will discuss the development of workplace union organisation amongst hospital nurses in Dublin and Naples. I will show that models of workplace representation in which union representation coincides with a personal relationship of trust between union members and representatives are preferred by Neapolitan nurses.

Another aspect of nurses' work relationships involves their relationship with line managers and Nurse Managers. I have already highlighted the issue of authority relationships between nurses at different levels in the 'nursing hierarchy', and these form an important part of nurses' relationship with their Ward Sister(s) and Unit Nursing Officers. There can often be an element of interpersonal conflict and antagonism in the relationship between nurses and their Ward Sisters, but it is important to stress that this relationship is also characterised by a high level of co-operation and trust. This is because the Ward Sister's role is primarily organisational, and does not generally involve the direction of Staff Nurses in individual tasks. The situation is completely different when we turn to management[144]. Nurses are highly critical of their managers, particularly in Italy:

> *[Researcher: In your opinion, do the Unit Nursing Officers play the role that they should?] All they do is manage their power [Researcher: Which is?] That of controlling overtime, and naturally they manage it to their advantage.*[145]

Arguably, the reason for this response lies with the role of nursing management, which is primarily concerned with staff allocation. Therefore, they are perceived as being responsible for maintaining and justifying current staffing levels, as one Unit Nursing Officer in the Irish case study hospital acknowledged:

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[144] In Italy, there is no Matron or overall Nurse Manager in the public hospitals, and the *Capiservizio* (equivalent to Unit Nursing Officers) report directly to the Medical Director, or *Direttore Sanitario* (see Chapter Three).

[145] Male Staff Nurse (41 years of age) in *Azienda*, Interview 2-19.

Since I've taken the UNO's position, I have done nothing constructive, it has been crisis management for the last seven weeks. It's pulling from Peter to pay Paul, to up the staffing levels, and I have done NOTHING constructive.[146]

The final element of this category of grievance concerns the relationship between nurses and their patients. Table 5.23 (below) summarises the evidence from the interviews with Irish and Italian nurses, revealing that staff shortages and heavy workloads have made it increasingly difficult for nurses to maintain a satisfactory relationship with their patients. As workloads have increased, nurses have also increased the intensity of their own work in order to avoid compromising the quality of patient care. However, because patients' physiological status takes precedence over their emotional state or psychological needs, nurses are often forced to focus on this area. The Chief Executive Officer of *Voluntary Hospital* made the following observation:

In the old days you'd have a ward of say 20 patients. Five of them would be at the convalescing stage, another ten would be middling acute and another five would be really acute. What's happening now is that there's no distribution, it's all acute. Bang bang bang, *and as soon as that person's fit to go home – gone. And with the step-down hospitals like Clontarf and things. Take Orthopaedics in our hospital here, we take all the trauma in, but we decant back out once we've done the operation, so we would have very acute sick people. The nurses wouldn't even get to say the rewards of even the acute stage. So that benefit of getting to know the patient// [//To what wards would that apply?] A lot of them.*[147]

In Naples, where staff shortages are more serious, nurses themselves often admit that the quality of care they provide is unsatisfactory. This is brought home by the issue of how nurses refer to patients. Every nurse knows, from their basic training (not to mention their common sense), that it is not acceptable to refer to patients by the number of the bed they occupy. Clearly, this contravenes every principle of individualised and holistic nursing care. However, in the context of very rapid turnover rates and serious

[146] Female Unit Nursing Officer (35 years of age) in *Voluntary Hospital*, Interview 1-8.
[147] CEO of Voluntary Hospital, Interview M-3.

under-staffing, nurses are often forced to adopt this shortcut. This encapsulates the alienation of modern nursing work in a busy acute hospital, and the shift to an 'assembly-line' model of hospital care. As Widgery (1979) remarks:

> *The problem of human relations in a hospital highlights the need to bring the hospital - as a social institution rather than a garage for bodies - back into society where it properly belongs.* (Widgery, 1979: 60)

Table 5.23 Grievances of Nurses Regarding Relationships with Patients

Extract No.	Hosp. No.	Age	M/F	Extract
103	No. 1	36	M	*... any eejit can look after a drip. A fourteen-year-old child can look after a drip so it's obviously... To me the essence of nursing as part of health is the interaction, the expertise and interaction that goes with that in addressing the whole person's needs. But it seems to me that even within the community we're focused on symptomatic treatment of illness and disease and that whole agenda doesn't operate outside those nice books*
104	No. 1	25	F	*Lately it's been terrible because we're so short-staffed and you'd be sitting with somebody who's just been given a dreadful diagnosis and you're the person they want to talk to and you're being called off because somebody's fallen and you have to leave them mid-sentence and you can't stay and that's very frustrating*
105	No. 1	28	F	*I remember one night we had a woman, she was getting out of bed and she tripped over something, and this other girl – she would have been 21 or so – and she came out of the room SCREAMING. Now we actually thought she had found somebody dead, the way she was hysterical. And it was just a woman had fallen! We were actually laughing – God forgive us...*
106	No. 1	35	F	*So I can do all of that without ever seeing the patients, which isn't right really. I would prefer it if I could see the chart, the x-ray AND the patient and then triage them through. In terms of communicating, you come outside the door to a sea of a hundred faces and you stand there and you say 'this is what is happening, over here and over there'*

Table 5.23 *Continued*

Extract No.	Hosp. No.	Age	M/F	Extract
107	No. 2	43	M	*... the nurse has to bring the disease under control, it has to be dealt with in so many days... Everything is computerised. Direct contact with the patient, the possibility of creating a relationship of mutual respect, based on trust, no... The patient is like a factory-produced good ...*
108	No. 3	44	F	*... (the patients) make you lose your patience because they don't understand how much you are giving them in that moment. ... But people are used to paying for health care, and more often than not they try to quantify in financial terms what you are giving them*
109	No. 3	53	M	*[So you are saying that it has become more mechanical, less human?] Yes, less human. The patient is not looked after. The patient might be better off now, but he/she is not looked after. Nowadays the patient is only a means for making money, and that's all*
110	No. 3	34	M	*I have also received threats from some of these characters (i.e. violent patients), and when you find yourself having to deal with them, I'm telling you... When you go to give them their injection, you feel a certain fear, because if things don't go well... It could happen, no?*

Self-Realisation and Professional Growth

I will now describe the final category of work grievance, which comprises issues of professional development and self-realisation. As I suggested earlier in this chapter, nurses – in common with a number of other occupational groups – do not relate to their job in the form of a straightforward 'employee' orientation, but also invest heavily in nursing in terms of their aspirations for self-development and self-realisation. Quite simply, nurses look to their job as a source of personal self-worth and satisfaction. This simple point is quite often overlooked. Its significance will become clear in the following chapter, when I will explore its impact on union representation amongst hospital nurses.

This category of grievance partly overlaps with the previous seven categories, as the preconditions for a sense of self-realisation involve adequate staffing levels, remuneration, autonomy, availability of equipment and beds, facilities for nurses, health safeguards, the possibility of establishing non-oppressive relationships with work colleagues and patients and flexibility in working hours. However, 'self-realisation' goes beyond mere 'satisfaction' to embrace more specific issues, such as the intrinsic interest, intellectual challenge or even difficulty of the job. This aspect of the nursing labour process has not received sufficient attention, and should be considered a fundamental part of the subjective experience of nurses (and of many other workers). The following extract represents a good example of this type of grievance:

> *I don't know what to do. I need to do something, but... I suppose I want a job like a coordinating role where I would be very challenged, I would be... I like educating patients, as I was saying. I want to be a Counsellor or Coordinator, but yet I want my weekends off, I want regular hours.*[148]

This category of grievance is much more accentuated amongst the Irish nurses, which suggests that these young, highly-educated and highly-motivated nurses also have high expectations. If we define self-realisation as the satisfaction that follows from realising one's capacities, it is possible to appreciate that the willingness of young nurses to undertake additional courses at their own expense is determined by their desire to gain a greater insight into the pathologies and difficulties that their patients experience. Nurses can enhance their capacities in this way and derive greater satisfaction from their ability to work more autonomously. As I will show in Chapter Six, this tends to lead to a more individualistic orientation towards nursing which contrasts with the greater collectivism observed in Naples. Nevertheless, young Italian nurses – both male and female – occasionally express similar aspirations, often in the form of a generalised dissatisfaction with their current situation or a feeling that nursing has failed to live up to their expectations.

[148] Female Staff Nurse (31 years in age) in *Voluntary Hospital*, Interview 1-2.

This helps to explain why the 'professionalisation' project attracts many young nurses, as it promises a more demanding, but also more satisfying role for nurses. I have tried to show that this 'blueprint' abstracts from the material constraints which exist in relation to the management and funding of health care, and I have argued that it can only be successful if it is limited to a small minority of the nursing labour force. However, there is another contradiction within the professionalisation project, as it relies on the codification of a distinctive body of knowledge – 'nursing studies'. This leads it to focus increasingly on the clinical role of nurses in specialist areas, for example, and on the managerial role of Ward Sisters and service managers. All attempts to ground the 'therapeutic relationship' in a codified body of knowledge ('the nursing process', 'nursing models' etc.) have failed to have anything but a very minor practical impact on nursing work. Nurses trained in these methods typically fail to put them into practice – primarily because of excessive workloads and the nature of their work relationships. Naturally, where the decision to become a nurse was imposed due to the lack of jobs, motivation will tend to be lower, and it is unsurprising to find disillusionment with nursing and a lower level of attachment to the notion of 'professionalisation' amongst older Neapolitan nurses.

Summary

In this chapter, I have shown that there are strong similarities between the issues identified by Irish and Italian nurses as 'grievances' and the ways in which they approach these issues. Statistical analysis of survey responses relating to grievances provides strong evidence that these similarities are rooted in structural features of nurses' work situation following health service rationalisation, and are not determined by individual attributes such as gender, age or marital status. One of the main findings of the research is that nurses' grievances embrace staffing levels, workloads, the organisation of shifts, hours of work, stress, the quality of care, professional roles, facilities and work relationships, and therefore go beyond the question of wages and increments.

In fact, the level of anger over wage levels expressed by the interviewees and survey respondents was considerably lower than in relation to the issues mentioned above. This was true of all four case study hospitals, in Ireland as well as Italy. In part, this reflects the specificities of wage grievances and their ability to act as a channel for other frustrations. It would therefore be misleading to suggest that nurses are not concerned about their salaries. However, the evidence presented in this chapter suggests essentially that *no amount* of increased pay will eliminate the frustrations and anger that nurses experience in relation to their non-pay grievances.

The typology of work grievances used to structure the preceding discussion of grievances is based on a series of analytical distinctions. These distinctions are useful when seeking to understand work grievances, but do not correspond to sharp boundaries in nurses' evaluations of their situation. For example, there is obviously a close relationship between work intensity, working hours and staffing levels, and I have shown how work intensity is intimately related to the quality of the nurse's relationship with his or her patients and colleagues. On the contrary, most nurses assess their situation in a holistic fashion, balancing different aspects of their work against each other.

A 'cost-accounting' metaphor is often used to carry out this evaluation, where advantages represent 'credits' and different kinds of grievances enter as 'debits'. This metaphor extends the notion of the 'wage-effort' bargain, which sociologists have discussed in a variety of contexts (one of the earliest examples is Behrend, 1957). Thus, it is common for nurses to remark that their attachment to nursing and the satisfaction that it gives them compensates, at least in part, for their inadequate remuneration and lack of recognition. It is also easy to understand why the nursing unions in Ireland have emphasised the question of wages and differentials to the exclusion of nearly all other issues. This is advantageous as far as the union leadership is concerned, as wage levels can be determined within a relatively straightforward bargaining process. During the nurses' pay campaign, the Nursing Alliance unions skilfully linked wage increases and incentives with the 'recruitment crisis' in nursing by arguing that wage increases would lure nurses back into the workforce, easing some of the pressures on staffing levels.

However, the evidence from *Voluntary Hospital* (which was up to its full quota of nursing staff at the time when field research was carried out) suggests that the recruitment crisis had a much smaller effect on nurses' work grievances than the rationalisation of the Irish health service during the late 1980s and early 1990s. In this context, it is important to note that the translation of non-pay grievances into claims for increased remuneration, even where successful (as in Ireland in 1997 and 1999), can lead to a sense of demoralisation amongst nurses (cf. Neale, 1982). This is because a wage rise – even a substantial increase – does not change the reality of nursing in the context of staff shortages and overcrowding.

The rationalisation of the health service in Ireland and Italy has been accompanied by ministerial declarations regarding the ability of managers to address the grievances of staff members at local level (Department of Health, 1996b; Department of Health and Children, 1997a; France, 1999). It will be clear from the analysis provided in this chapter that managers may be able to resolve certain grievances by improving the coordination of services, by ensuring that the necessary materials are made available, by organising training and by providing uniforms and changing-rooms. This potential corresponds to the role of management *within* the labour process in providing the 'function of co-ordination' (Armstrong, 1991; Carchedi, 1987). The decentralisation of decision-making authority in relation to issues such as these therefore provides the potential – at least in principle – for tackling certain grievances.

However, these improvements are likely to depend on nurses' ability to create effective workplace union structures and to use these to influence managers' decisions. Firstly, marketisation institutionalises pressures to cut costs, and this has an impact on the willingness of managers to address nurses' grievances. This phenomenon has been intensified by the introduction of performance pay in Italy, leading to the payment of incentives to managers who make a 'profit'. Secondly, the rationalisation process emphasises the role of the 'consumer' in choosing between rival service providers and highlights 'customer satisfaction' as the main focus of strategic management. As the experience at *Azienda* indicates, this tends to favour external appearances (entrance halls and corridors) over 'backstage' areas such as changing-rooms and nursing stations. It was apparent from the interviews that managers increasingly view nurses as an

'expendable resource', exploiting their commitment to patient care in order to compensate for increasing rates of patient throughput, higher dependency ratios and even falling staffing levels.

But the main obstacle to the resolution of nurses' work grievances at local level lies with the fact that health service rationalisation has involved a *strengthening of central control* over overall spending and staffing levels. Because wage costs account for a large proportion of total health spending, the creation of new jobs has become much more difficult. I showed in Chapter Two that health service rationalisation was initially implemented by means of a 'recruitment freeze', the imposition of limits on hospital budgets and the closure of hospitals and wards. Therefore, grievances in relation to short-staffing, workloads, shift organisation, working hours, patient care and self-realisation are likely to persist for the foreseeable future.

Despite their inter-relationships, therefore, work grievances have a resilience – an irreducible core – and this is of crucial importance as far as union representation is concerned. This will be the subject of the next chapter, and I will therefore conclude by quoting David Widgery (1979), who situates work grievances in the context of the hospital labour process and hints at their importance for studying nurses' workplace union organisation:

> *A hospital has a single aim which is carried out in a multitude of different but interdependent labour processes, each with its own species of grievance: the student nurse wants another gas-ring in the sitting-room, the night porters are worried about their overtime, the assistant orthopaedic appliance maker wants upgrading. It has only been as the rank-and-file hospital unions have taken up day-to-day issues that they have dented the rigid classifications of skills and jobs that keep all health workers compartmentalised, and the union has taken on a real meaning in the hospital. And to do this they have had to fashion their own informal union structures.* (Widgery, 1997: 116)

VI THE REPRESENTATIVE RELATIONSHIP: NURSES AND THEIR UNIONS

Introduction

In Chapter Three I described the responses of the union movement in Ireland and Italy to health service rationalisation, concentrating on the strategies of the union leadership and the positions adopted by different union actors. My aim in this chapter is to provide an alternative perspective on union responses by focusing on the relationship between nurses and their unions within the hospital setting. In addition to studying the positions adopted by union leaders, it is important to analyse how union representatives have responded to specific interventions at local level and how the decentralisation of decision-making has influenced workplace union organisation.

I will begin by defining the relationship between nurses and their local representatives as a 'representative' relationship and by situating this within the wider context of social relations within the hospital. This will lead to a review of theoretical debates about the nature of workplace union representation. I will then present an empirical analysis of the interview and survey data from the case study hospitals and provide an assessment of the contrasts and commonalities that may be observed between union representation in Ireland and Italy.

I showed in Chapter Three that the union leadership in both Ireland and Italy assented to changes in the financing, organisation and management of the health service during the late 1980s and early 1990s, albeit with certain reservations. I argued that the unions' support for rationalisation, reform and 'modernisation' was conditioned by their integration into neo-corporatist bargaining arrangements at national level. Although union leaders expressed reservations about the scale of the rationalisation process, the severe economic crisis that formed the backdrop to policy reform increased the pressure to accept the changes. Furthermore, the possibility of participating directly in the implementation of the new policies provided a strong incentive to union leaders, who were concerned not only about national economic competitiveness but also about the

ability of the health service to satisfy public demands for high-quality, effective health care (McAuliffe, 1998).

As the resulting policies have been implemented, however, the unions' acceptance of managerialism, organisational change and marketisation has given rise to tensions, as these processes have had a number of negative effects on the nursing labour process (see Chapter Five). At the same time, the decentralisation of financial responsibilities and managerial decision-making poses challenges for local unionism, as the emergence of a relatively autonomous, strategic management function in at least some of the large acute hospitals has led to a sharp increase in the pace of organisational change.

In the course of this chapter, I will draw on interviews with 55 hospital nurses (13 of whom currently represent a union at hospital level) and 11 full-time union officials. I will use survey data to evaluate overall levels of union membership and participation and to explore the relationship between work grievances, nurses' orientations towards their job and their involvement in union activities[149]. Statistical modelling techniques will be used to assess the determinants of union membership and to examine differences in the composition of the different unions found in the case study hospitals.

The 'Representative Relationship'

Workplace union representation is subject to a rather different set of pressures compared to national representation and involves a dynamic – and often contradictory – relationship between union representatives and their members. I will refer to this as the 'representative relationship' in order to emphasise its relational aspects and sensitivity to social context. This relationship is simultaneously dyadic and collective in nature, as the union member is represented both as an individual and as a member of an occupational group, category or sector of employment.

Union representation is also structured in a hierarchical manner, typically assuming a distinct form at the level of the workplace, local area or branch, region and nation. The

[149] See Appendix A for further details on the questionnaire survey and Appendix B for a description of the collection and analysis of the interview data.

relationship between different levels of union representation varies over time and space due to political and ideological traditions within the labour movement and the structure of collective bargaining. Whereas workplace union representation is often founded upon a face-to-face relationship between the individual union member and the union representative, union representation at higher levels is mediated by formalised structures of decision-making and communication. The *role* of workplace union representation is also different to that of national representation, being concerned primarily with grievances that emerge within the hospital context and with negotiations over changes in working conditions. In structural terms, therefore, workplace union representation is defined by its restricted sphere of influence, its subordination to decisions made at higher levels of union representation, its dependence upon regional and national union leaders, the direct relationship between union members and their representatives and its sensitivity to grievances arising within the labour process.

Theoretical Framework

Marxist approaches to union representation highlight the fact that unions are involved in a contradictory struggle *within* as well as *against* capitalism. Union representatives typically express the grievances of their members whilst limiting themselves to forms of protest that do not jeopardise existing social structures and prevailing bargaining arrangements. As a result, all union representatives are subject to a tendency towards accommodation with their negotiating partners, and this applies to workplace representatives as well as national officials (Beynon, 1973). When the balance of workplace power is relatively unfavourable to workers, accommodation with employers often becomes a tactical necessity. The tensions inherent in union representation thus demarcate a sphere of strategic action in which workplace representatives must make difficult choices and adapt to circumstances not of their own making:

> *The tension between the need for trade union organisation and mass participation in that organisation is a vital and irresolvable one. A gap exists between the shop stewards and the rest. A gap created by the very fact of sustained activism and enforced by its organisation. Ultimately there is no way out of this. The complexity of modern society coupled with the physical and mental strains of factory work*

> *make some form of 'full-time' activism essential. Even at the shop floor level. In coping with this the shop steward finds himself torn between the forces of representation and bureaucratisation. Between the need to represent the immediate wishes of the members and to provide a long-term strategy that will protect the interests of those members.* (Beynon, 1973: 206)

I will refer to the above tendency towards compromise and accommodation, inherent in the very structure of collective bargaining, as 'routinisation', and I will distinguish between this and the notion of 'bureaucratisation'. The 'theory of the union bureaucracy' represents the most controversial element of the Marxist account of union representation. According to this theory, the material conditions of full-time union officials predispose them towards a relatively cautious and conservative stance as far as industrial action is concerned. It is argued that the comfortable working conditions and job security of union officials and the difference between their salaries and those of their members have an impact on their general outlook. They do not have the same material incentives to defend working conditions and to fight for improvements in pay. Secondly, full-time union officials are largely isolated from contact with their members by their work location, tasks and social milieux.

It is also argued that union officials are vulnerable to the influence of the media because they are viewed as being 'responsible' for all industrial action taken by their members. Moreover, the involvement of union officials in negotiations with employers and government ministers induces them to favour compromise and accommodation over conflict and struggle. Essentially, they come to see their own bargaining role as the key to securing favourable outcomes. Finally, the status and influence of union officials depends, at least in part, upon the financial and organisational stability of their union, which tends to encourage a conservative attitude towards actions which may threaten these resources and their 'good working relationship' with employers and Government (Callinicos, 1995: 17-18).

Kelly (1988) criticises this theory, emphasising the interdependence between officials and stewards and the omnipresence of tendencies towards 'reformism' within the union movement. Although union leaders may earn more than their members, he argues,

workers with above-average earnings, job security and status are often the most militant. Moreover, the term 'bureaucracy' is at best imprecise, as trade unions do not contain a clearly-demarcated group of employees selected on the basis of professional qualifications, controlled by a unified disciplinary system and rewarded by means of a career structure and salary scales (i.e. employing the Weberian definition of 'bureaucracy'). If we look at the historical record and the results of empirical analyses, he continues, union leaders have not always been more conservative than their members, and their willingness to lead campaigns of industrial action depends more on the historical period than their membership of a 'bureaucracy'. Fosh and Heery (1990) adopt a similar stance, arguing that full-time union officials typically have many years of experience as lay activists within the union and are "very effective industrial relations operators" (p. 100-101), capable of broadening the scope of collective bargaining whilst also defending the 'fabric of union organisation' (p. 91). After observing interactions between full-time union officials and 'lay' representatives, they conclude that the former are no more conservative or cautious than the latter and, on the contrary, may be more sensitive to issues of discrimination and equal rights, for example.

Hyman (1979) also criticises the theory of the union bureaucracy, and, like Beynon, attributes the main tensions within the union movement to the function of collective bargaining. Whilst accepting that there is a 'problem of bureaucracy', he argues that "to build our whole analysis of trade unionism around the notion of bureaucracy is to make a specific group of personnel the scapegoats for problems which are more diffuse and more pervasive" (Hyman, 1980: 74). Zeitlin (1989) and Thompson & Lewis (1977) follow a similar line: "It is the bargaining function, not the existence of trade union bureaucrats as a separate group in the division of labour with their own distinct interests, that creates the conditions for social privileges" (Thompson and Lewis, 1977: 31, quoted in Kelly (1988: 48); see also Batstone, 1988). In slightly different vein, Fairbrother and Waddington (1990) argue that "[i]f it is argued that bureaucracy pervades trade union practice at every level, the countervailing tendencies towards democratic relations must be similarly pervasive. Analyses omitting consideration of this inherent tension run the risk of fatalistically accepting the 'inevitability' of bureaucratisation..." (p. 43).

If the theory of the union bureaucracy is understood in static terms as describing a dichotomy between the 'rank and file' and union 'officialdom', it clearly has low explanatory power: a disparate range of outcomes may be cited as 'confirming' the theory, which remains immune to counter-examples. In this case, the terms 'rank and file' and 'union bureaucracy' become rhetorical tools rather than scientific concepts. If, however, we focus on the notion of 'bureaucratisation' as a process that coexists with other tendencies and counter-tendencies, it is possible to provide a more historical, nuanced account of the tensions within union representation. In fact, the tendencies described by Callinicos (1995) do not imply that union officials will *always* be more conservative than union members, as Kelly and Fosh & Heery suggest (cf. Zeitlin, 1989). Rather, it implies that the material situation of union leaders becomes relevant primarily in situations of social polarisation, when the mobilisation of union members raises questions about the aims, forms and limits of collective action.

It is relatively straightforward to find examples of this process. As I showed in Chapter Three, the dramatic increase in workplace participation and militancy during the 1960s and 1970s in both Ireland and Italy generated conflicts between union activists, who had been radicalised by the upturn in industrial struggle, and union leaders, who were concerned about the impact that these struggles might have on established industrial relations procedures, on the competitiveness of national capital and the balance of political power at national level. Similarly, during the nurses' pay campaign in Ireland in the late 1990s, union officials sought to place limits on the expectations and demands of nurses as they were worried about the negative consequences that militant industrial action might have on the system of tripartite agreements at national level. Nevertheless, there were considerable differences between the outlook of different union officials and *all* of the union leaders ultimately accepted the need to take members' demands seriously.

I would therefore suggest that Hyman, Thompson & Lewis and Kelly are correct to argue that tendencies towards routinisation within unions are rooted within the structure of collective bargaining and that this tendency permeates every level of representation. However, I believe that it is a mistake to juxtapose this to the notion of 'bureaucratisation', as the latter refers to a different process, one which only affects full-

time union officials and which arises from their material conditions, social function and organisational role. In fact, the concept of 'routinisation' makes no reference to these aspects of the situation of union officials. These two tendencies coexist, and empirical research is required in order to assess their influence in specific circumstances and in order to evaluate the relative importance of the counter-tendencies that I will discuss in the following section.

Counter-tendencies to Routinisation and Bureaucratisation

Labour Process theorists have also addressed the tensions within union organisation and their work provides a number of useful insights into the nature of 'routinisation', 'bureaucratisation' and contrasting tendencies such as 'union democracy'. Unlike Fairbrother & Waddington (1990), Darlington (1993, 1994, 1998) locates tendencies towards 'bureaucratisation' and 'resistance' at different levels of the union hierarchy. Although bureaucratisation originates at the top of the union, it can penetrate as far as workplace organisation, where it is counterbalanced by pressures for democracy and participation emanating from the membership (Darlington, 1994: 30-32). Darlington nevertheless believes that the dichotomy between the 'rank-and-file' (union members and unpaid representatives in the workplace) and the 'union bureaucracy' (full-time officials) is meaningful. However, he stresses that the term 'rank and file' represents a simplification of the complex differentiation between full-time convenors, senior shop stewards, lay sectional stewards, union activists and members (cf. Cronin, 1989; Price, 1989; Zeitlin, 1989).

In addition to Fairbrother and Darlington, a number of other writers have emphasised the role of participation and union democracy in sustaining the vitality of local union structures. For example, Cohen & Fosh (1988) argue that "where organisation and decision-making are left up to the representatives, local trade unionism loses its strength" (1988: 5). The most important ingredient of workplace unionism, according to these authors, is the maintenance of regular contact between representatives and members in order to keep the latter informed about union activities and in order to encourage participation:

> *There has to be a strong commitment from local representatives towards the maximum involvement of members, and such a commitment can only flow from a collective perspective.* (Cohen & Fosh, 1988: 32)

Terry (1983) contrasts 'participatory' and 'representative' forms of democracy, arguing that the active involvement of union members is crucial to the maintenance of strong workplace organisation. Callinicos (1995) also emphasises the role of workplace participation, arguing that democratic procedures for electing and replacing workplace representatives provide an important counterweight to 'bureaucratisation'. The fact that British shop stewards typically work alongside and receive the same wages as their members, are elected regularly and remain directly accountable to their members constitutes a counterweight to the routinisation and bureaucratisation of union representation. Callinicos extends these comments to workplace representatives who work full-time for their union: "...despite the development of the full-time convenors, shop stewards' organisation remains qualitatively different from official union structures in its potential responsiveness to rank-and-file pressures. Even full-time stewards are normally subject to regular elections. They are liable to victimisation by management and will lose their jobs if their plants are closed" (Callinicos, 1995: 56).

To recapitulate, although workplace union representatives may in certain circumstances lose their independence from management and grow more distant from the membership, the ability of union members to replace their representatives and to place constraints on their behaviour provides a 'cure' for routinisation and bureaucratisation. Although this account of workplace union democracy must be qualified in a number of respects, the main conclusion is that democratic participation can counterbalance negative trends in workplace union organisation.

It is important to realise that the effectiveness of participation and union democracy as counter-tendencies to routinisation and bureaucratisation depends upon the organisational form of workplace unionism and the political traditions that it embodies. In contrast, there is a tendency within the Anglo-Saxon literature to assume that shop steward organisation represents a relatively unproblematic and organic form of union representation. The adoption of a comparative approach can therefore provide a

contrasting perspective on this issue. The reform of collective bargaining in Italy during the 1990s provides a clear example of how organisational forms can both facilitate and constrain workplace democracy (see below), and the emergence of the rank-and-file unions in Italy has provided an alternative model of workplace unionism which differs markedly from British steward organisation, necessitating a more sophisticated theoretical approach. The social embeddedness of the 'representative relationship' reduces the relevance of abstract typologies such as that provided by Darlington and problematises his exclusive focus on stewards as the direct expression of 'rank and file' interests. These considerations reveal some of the limitations inherent in the dichotomy between 'bureaucracy' and 'rank and file': the inclusion of union members and workplace representatives within a single category obstructs careful analysis of what I have referred to as the 'representative relationship'.

The organisational form of workplace unionism is closely connected with political traditions within the labour movement, and these have also been discussed within the literature on workplace unionism. Following Cohen & Fosh (1988), Cohen & Moody (1998) argue that a 'collectivist' outlook is central to the maintenance of participatory and democratic forms of workplace organisation, and that this requires more than mere 'union militancy' (p. 117). In order for unions to maintain their capacity to defend pay and conditions they must develop "a level of awareness of the overall meaning and direction of management strategy which in effect exposes its roots in capitalist production relations centring on exploitation" (Cohen & Moody: 117). The authors emphasise that this process involves building on the political implications of 'everyday' working-class struggle, pointing to the example of *Labor Notes* and *Teamsters for a Democratic Union* in the United States.

Dundon (1998) refers to the role of 'wider social and political networks' in shaping the behaviour of union representatives, emphasising the importance of the history of political affiliations within local union structures. Darlington (1994) also argues that we should pay 'much greater attention than hitherto' to the relationship between workplace organisation and the "ideological and political resources that underpin the leadership strategies of shop stewards" (p. 1). Industrial action rarely occurs 'spontaneously', and some form of initiative, organisation and leadership is usually required in order to

overcome the fragmentation of workers' experiences. As Darlington indicates, there is a danger that participatory and democratic forms of workplace unionism remain confined within the workplace; this represents a limitation on its ability to counteract routinisation and bureaucratisation at higher levels.

Union Composition in the Case Study Hospitals

In this and the following sections, I will use the interview and survey data collected in the case study hospitals to evaluate the nature of the representative relationship in the Irish and Italian health services and to assess the responses of nurses and their unions to rationalisation. I will begin by describing, in broad terms, the fundamental strengths and weaknesses of union organisation in the case study hospitals[150]. The highest unionisation rate is observed in the Irish context, where 88 per cent of survey respondents are union members. The vast majority of these nurses (97%) are members of the Irish Nurses' Organisation (INO).

This compact, near-universal union coverage contrasts with the pattern of unionisation found in the Neapolitan hospitals, where just over half (54%) of hospital nurses are in a union and where union representation is highly fragmented. Significant inter-hospital differences are observed in relation to union coverage and composition. Table 6.1 provides a breakdown of union membership rates in the Italian hospitals by gender, and reveals a difference of more than 11 percentage points between men and women. Whereas 57 per cent of male nurses are union members, this applies to only 46 per cent of female nurses. Moreover, as Table 6.2 shows, union membership peaks in the age group between 40 and 49 years (64%), dropping to 40 per cent for the youngest cohort (under 30) and to just over 50 per cent amongst those aged over 50. If we control for both age and gender, we find that women aged under 30 are much less likely to join a union than their male counterparts (27% as opposed to 56%), although the differences are smaller within the older cohorts[151]. In the Irish case study hospital, union

[150] Note that all percentages reported in the following paragraphs relate to the case study hospitals alone.
[151] 45% of women aged 30-39 are in a union, compared to 47% of men, 59% of women aged 40-49 are union members, compared to 65% of men and 48% of women over 50 are members, compared to 53% of men.

membership shows a similar pattern with age, although even amongst nurses under 30 years of age a very high level of membership is observed (85%).

Table 6.1 Union Membership in the Case Study Hospitals by Gender

	Ireland			Italy		
	Female	Male	Total	Female	Male	Total
Non-member	*12.2%*	*25.0%*	*12.4%*	*53.9%*	*42.7%*	*46.2%*
Union member	*87.8%*	*75.0%*	*87.6%*	*46.1%*	*57.3%*	*53.8%*
Respondents	*254*	*4*	*258*	*154*	*337*	*491*

Table 6.2 Union Membership in the Case Study Hospitals by Age

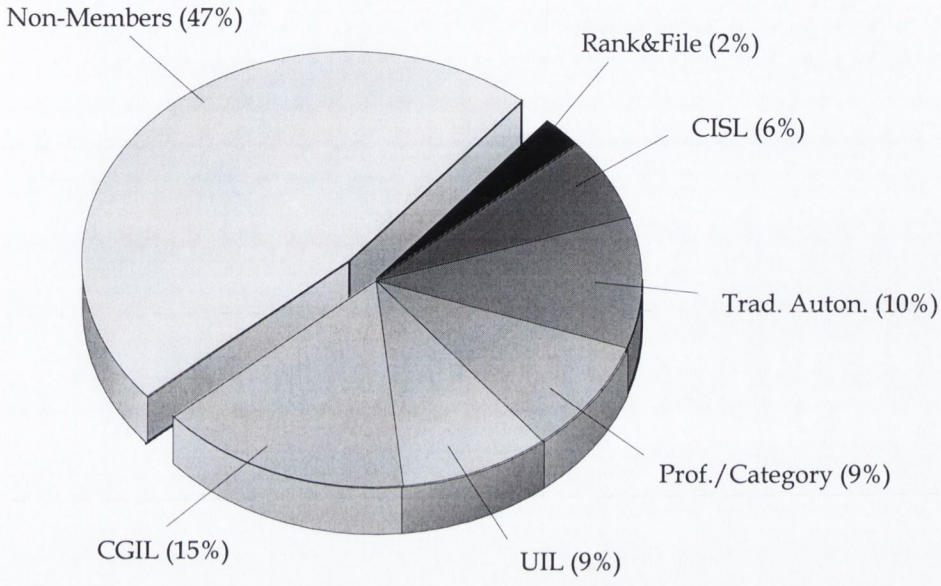
	Age in Years				
	<30	30-39	40-49	50+	Total
IRELAND					
Non-member	*14.8%*	*11.8%*	*4.8%*	*7.7%*	*12.7%*
Union member	*85.2%*	*88.2%*	*95.2%*	*92.3%*	*87.3%*
Respondents[152]	*142*	*76*	*21*	*13*	*252*
ITALY					
Non-member	*60.0%*	*54.8%*	*35.8%*	*49.4%*	*45.5%*
Union member	*40.0%*	*45.2%*	*64.2%*	*50.6%*	*54.5%*
Respondents	*20*	*157*	*215*	*83*	*475*

Figure 6.1 (below) shows that the largest union with nursing members in the Neapolitan hospitals is the *Confederazione Generale Italiana del Lavoro* (CGIL), accounting for over one-quarter of union members (29%). *The Unione Italiana del Lavoro* (UIL) has 18 per cent of unionised nurses, followed by the *Federazione di Associazioni Professionali Addetti alla Sanità* (FAPAS), with 16 per cent, which is the main union within the category 'professional and category-based unions' in the graph below (see Chapter Three for a description of the origins of these unions). The current strength of the category-based FAPAS is due to its rapid growth in recent years. In this sample it eclipses the *Confederazione Italiana dei Sindacati dei Lavoratori* (CISL), with just 12

[152] The slight discrepancies between the number of cases in each age group in this table and in the tables dealing with grievances in Chapter Five are attributable to the effects of nonresponse to certain questionnaire items.

per cent[153]. The only other union to account for more than 5 per cent of unionised nurses is the *Confederazione Italiana Sindacati Autonomi dei Lavoratori* (CISAL), which is included amongst the 'traditional autonomous unions' (Trad. Auton.) in the graph.

Figure 6.1 Union Composition in the Case Study Hospitals in Naples

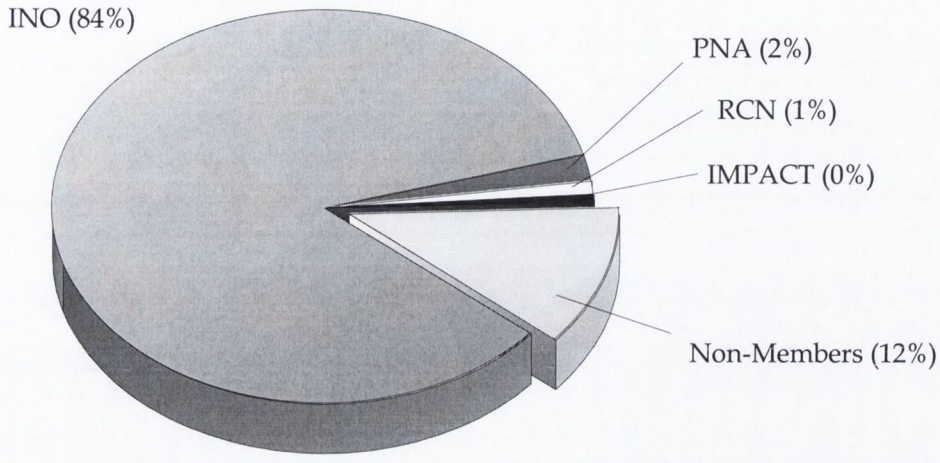


It is a much more straightforward task to describe the composition of the Irish case study hospital (Figure 6.2). As far as nurses are concerned, Irish hospitals are characterised by strong and relatively exclusive local traditions of union organisation, with a marked polarisation between the *Irish Nurses' Organisation* (INO) and the *Services, Industrial, Professional and Technical Union* (SIPTU), the former enjoying a dominant position at national level. The *Psychiatric Nurses' Association* (PNA) and the *Irish Municipal Public and Civil Trade Union* (IMPACT) tend to be confined to Psychiatry/Mental Health and Administration, respectively. Our case study hospital reflects this overall situation: the INO completely eclipses SIPTU, just 2 per cent of nurses belong to the PNA, three nurses (roughly 1 per cent of the total) are members of the Royal College of Nursing (RCN) and just one person is a member of IMPACT.

[153] Bordogna (1994), reporting on union membership amongst a sample of hospital workers in the late 1980s, identified the share of the confederal unions as 71% (CGIL 22.6%, CISL 14.6%, UIL 33.5%), 4.3% for the autonomous unions, 20.7% for the 'new organisations' (such as the rank-and-file unions) and 4.3% for 'other organisations'. These results are certainly not representative of the national picture, as national data on union membership in 1988 gave the CISL a 24% share of hospital workers and UIL 16% (no data for the CGIL were available at this point). These differences indicate the considerable variability in membership levels and union composition observed at local level.

Most of the RCN members are INO members, and this also applies to the single IMPACT member.

Figure 6.2 Union Composition in the Case Study Hospital in Dublin



It is important to stress at this point that high levels of union coverage do not necessarily translate into strong local union organisations. At a superficial level, the high level of unionisation and the concentration of union members in a single organisation in the Irish case study hospital suggest that workplace union representation is stronger here than in the Italian hospitals. However, as I will show, the Irish nursing unions are characterised by low levels of membership participation at local level despite the high levels of unionisation observed. Moreover, there are strong union traditions within the Italian hospitals despite the recent decline in membership levels. Before analysing this decline, I will provide a brief summary of the motivations that nurses give for joining unions and their reasons for choosing specific organisations.

Union Choice

In the Italian case study hospitals, the justification most often provided by nurses for joining a union involves questions of political identification (this applies to roughly half of those interviewees who were willing to comment). The following extract is representative in this regard:

> *[Researcher: Why did you choose the CGIL at the beginning?] I chose the CGIL above all because it contained Communist Party and Socialist Party members, in other words it was a very left-wing union. [Researcher: It was more involved in workers' struggles?] Yes.*[154]

This clear 'political' motivation for joining a confederal union is obviously a result of the consolidation of a 'party-ancillary' union movement in Italy during the post-war period (see Chapter Three). There is no analogous pattern of union choice in Ireland. After political criteria, the next most common reason cited by Italian nurses for joining a union is personal familiarity with the union representative (this applies to roughly one quarter of the interviewees):

> *[Researcher: Why did you join the UIL?] Because there was a friend of mine, somebody I knew, a very bright person. Somebody who I could see was not looking for anything for himself, but stuck up for what was right.*[155]

> *[Researcher: And why did you choose the CISL?] Well, it's always because, you know, there's a colleague working in the same ward who says to you: "you're not in the union, you should join – you know a union can always come in handy…". In the end, they convince you to join... So in my case there was no political motive involved or ideological preference. I have joined again here because I was given the names of two work colleagues who I know and respect, and I think that they can provide the right kind of representation.*[156]

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[154] Male Staff Nurse (42 years of age) in *Azienda*, Interview 2-2.
[155] Female Midwife (45 years of age) in *Presidio*, Interview 3-6.

Once again, this represents a strong contrast between Ireland and Italy, as the relatively exclusive local traditions of INO and SIPTU membership amongst nurses and the weakness of workplace union organisation means that personal relationships play a much less important role in recruitment.

The next most common justification for joining a union amongst Italian nurses is related to its 'professional' outlook or attributes, followed by the need to tackle work grievances within a specific context and the need for unity during periods of industrial action. Whatever the reason for choosing a specific union, most nurses express a strong belief in the union movement and the value of union representation:

> *I have always been a union member because I BELIEVE in unions. I have even changed unions, but it is precisely because the union, in my opinion... Whether it has one particular derivation or another, the union is there to defend the workers. For which// [Researcher: //And there's a need for that?] And it has to be there – but it should act in the right way. Because I believe in this principle, I have remained a member, because I think: "If I am right to think in this way, and if my protest can only take the form of cancelling my membership, the only thing that I will achieve is that I will weaken the union". That is the mechanism that has... that convinces me to remain in the union.*[157]

Once again, this represents a strong contrast with the orientations of nurses in the Irish case study hospital:

> *[Researcher: Well, in general do you think a trade union is necessary for nurses?] (pause) Like, more so than the INO do you mean? The INO is not really a union, it's just an organisation, well I suppose maybe.*[158]

Nevertheless, it is important to note that a minority of Italian nurses – primarily younger nurses who have joined the hospital workforce since 1990 – have a negative attitude towards unionism and a more 'individualistic' outlook:

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[156] Male Staff Nurse (34 years of age) in *Presidio*, Interview 3-9.
[157] Male Ward Sister (44 years of age) in *Azienda*, Interview 2-8.

...in my opinion, they shouldn't even exist, everything should be done in accordance with the provisions of the contract, and that's it. In other words (speaking slowly and with emphasis) I don't agree with the role of the union, because by now I don't see any need for its existence. ... we have elected people at national level who legislate, who pass laws. These laws should be respected whenever an agreement is reached between a worker and his or her employer. The employer must provide the worker with a contract, and the INDIVIDUAL worker can decide whether that contract is acceptable.[159]

When asked why they joined their union, some Irish nurses indicated that localised forms of industrial action had encouraged them to join, or in some cases to rejoin, having allowed their membership to lapse. However, the reason for joining that was most frequently cited by Irish nurses was that they were encouraged to join whilst still attending a School of Nursing:

...it was always encouraged here. Even as students they always came in to talk to us. We were always encouraged to join and it automatically comes out of your wages or your salary and stuff so it's very easy. Even from first year I can remember in 1992, they used to come in and talk to us. [Researcher: Who came in, were they reps?] A rep, yeah, usually a nursing rep from the INO. [Researcher: From the INO itself?] Yeah, yeah and they would come in and encourage us to join and// [Researcher: //What kind of proportion of people joined at that point?] I'd say seventy percent.[160]

Voluntary Hospital does not have a history of union organisation and it is therefore likely that the encouragement provided by nurse tutors, managers and INO representatives was instrumental in creating the homogeneous union environment that is currently observed. Therefore, the development of union representation in this hospital appears, at least to a certain extent, to have been sponsored by nursing management. Obviously, as soon as one union achieves a dominant position at local level, individual

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[158] Female Ward Sister (42 years of age) in *Voluntary Hospital*, Interview 1-9.
[159] Female Staff Nurse (29 years of age) in *Presidio*, Interview 3-15.
[160] Female Staff Nurse (25 years of age) in *Voluntary Hospital*, Interview 1-5.

non-members have a strong incentive to join, particularly in the context of industrial action:

> *But the only reason people joined in the end – some of the people – was because of the whole difficulty we would have passing pickets. And because there were two duty rotas. If the duty rota of the strike went ahead to allow for the picket and who was going to cover, and people who weren't in a union were rostered for the line of duty on that rota, so it stood out like a sore thumb as to who was and who wasn't in the union. So I think a lot of people just didn't want to be singled out.*[161]

Nevertheless, a number of nurses in the Irish hospital also have specific reasons for preferring the INO over the available alternatives. For example, many nurses praise the INO for its exclusive focus on nursing staff:

> *I wouldn't join another union here, because I don't think... I like a union that is actually focused for nurses, and that seems to be the point. [Researcher: Why?] Because I don't think nursing IS professional, or semi-professional… But if you wanted to be professional and aspire to be that then you must... One of the things in that is being exclusive in your own agendas and, you know, if nurses continue to belong to occupations which aren't seen as remotely close to being professional, then we just devalue the whole thing...*[162]

This highlights an important difference between the outlook of nurses in Dublin and Naples, namely the relative importance of 'collectivism' and 'sectionalism'. In the context of the Italian labour movement, the term *corporativismo* (sectionalism) is regarded as an insult. During the course of the interviews with nurses and their union representatives, *every single union* was accused of this at one stage or another. This refers to a form of union representation that is concerned exclusively with the interests of a single group of workers. In contrast, solidarity and identification with the general interests of the entire working class are fundamental values:

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[161] Female Ward Sister (32 years of age) and union representative in *Voluntary Hospital*, Interview 1-7.
[162] Male Nurse Manager (36 years of age) in *Voluntary Hospital*, Interview 1-4.

[Researcher: Would you be willing to join a different union?] No. For the love of God, it's not that... I made an ideological choice, not one of convenience. Therefore, for me it would only be a question of convenience to change unions. [Researcher: The fact that the CGIL wasn't up to the task, let's say, meant that you couldn't join an autonomous union?] No, because as I said, they only carry out sectional battles, for single categories or even for single wards. Each has members in a different ward, and they only look after their own ward – not the best way of doing things![163]

Thus, the main difference between nurses in Ireland and Southern Italy in relation to their union orientation is the greater attention to solidarity and general forms of identification in Italy. This concern with collectivism is very deeply embedded in the political culture of unionism in Italy and contrasts with the greater individualism of Irish nurses. The individualism of the latter group is encouraged by a number of factors, including their high job mobility (many young nurses work for a few years in Ireland before travelling to Britain, America, Australia or the Middle East) and the fact that many of these nurses had not experienced collective action prior to 1999. It is also evident that many Irish nurses look to further training and professional qualifications as a vehicle for improving their working conditions, rather than focusing necessarily on collective organisation. For example, whereas just over 16 per cent of nurses in the Italian sample have a specialist qualification in addition to their basic diploma, this applies to no less than 48 per cent of their Irish counterparts. As well as answering the survey questions on qualifications, many Irish nurses provided an extensive list of the extra courses that they had attended and the certificates and postgraduate qualifications that they had attained. There is undoubtedly a gendered dimension to this aspect of Irish nurses' work orientations, and I will address this issue explicitly in the next section. In order to conclude the current discussion on forms of nursing union representation, it is worth noting that a more 'exclusive' approach is also sought by a minority of Italian nurses:

[163] Male Staff Nurse (41 years of age) in *Azienda*, Interview 2-19.

Why does it have to be by category? [Researcher: Yes, why?] Because it has to. Because, as I was saying, that way it will pay more attention to my grievances. That is, I mean to say, if the union has to represent nurses, auxiliaries, plumbers, electricians, porters and whatever – receptionists – it will end up looking after nobody.[164]

The main vehicle for these aspirations is the FAPAS union, which is not confined to nurses (who comprise 90% of the membership), but also recruits amongst paramedics and laboratory technicians. The Regional Secretary for the Campania Region describes its outlook:

We can truly say with pride that we were one of the first unions to adopt a category-based approach, and more than defending, to go and boost the professionalism of those who provide direct assistance… I'll give you an example: somebody who is lying on the ground injured. You can't just pick up an injured person like a head of broccoli. If there is an injured person lying on the road you need somebody who above all knows how to move them.[165]

Orientations of Hospital Nurses

Despite the differences noted earlier in the attitudes of Irish and Italian nurses towards their unions, there are few differences in the subjective militancy of these two groups, where 'militancy' merely refers to a willingness to take industrial action. Even INO members who value its 'exclusive' approach express considerable militancy, and many nurses criticise the INO for its lack of assertiveness during the early stages of the nurses' pay campaign (1996-7):

[Researcher: Would you vote for industrial action this time round?] Yeah, yeah (no hesitation). [Researcher: Do you think your colleagues//] //Everybody would. [Researcher: They'd vote for a //strike?] //Yeah. [Researcher: What about the issue of patient care, what about leaving the wards short?] It wouldn't leave the wards

[164] Male Staff Nurse (38 years of age) in *Presidio*, Interview 3-16.
[165] Antonio Mari, Regional Secretary of the FAPAS union in Campania, Interview U-7.

short because the way it was all planned the last time was that we would go out on a rota basis.[166]

[Researcher: Do you think that nurses need trade unions?] Don't get me started (laughing). My Dad is a unionist so he is all into the trade unions. I think nurses definitely need trade unions, I think that nurses need unions that will stand up for them, because I honestly don't think that the INO is standing up for the nurses. I think the worst thing they did was went back on that strike a few years ago. They really just, they are a laughing stock now.[167]

As I stated in Chapter Three, the growing militancy of Irish nurses erupted at the end of the 1990s in accordance with the 'pressure cooker' model of industrial relations. The culmination of this process was the national nurses' strike in 1999. During the run-up to the strike, hospital representatives organised strike committees, stood up to the power of Consultants in relation to staffing levels, called mass meetings, encouraged nurses to join the union and sought to boost the confidence and morale of union members. Localised forms of industrial action during the mid-1990s prepared the ground for the nurses' strike by boosting membership and participation levels and by showing that nurses can have considerable power when they act collectively. As a local representative in the Irish case study observes:

Nurses are great for giving out at local level, but they do nothing with it. Maybe it is because they have never seen a positive... I mean I suppose if they could have one positive experience then they would be more inclined to do it again.[168]

Another precondition for the strike was the influx of young nurses from a more urban and working-class background, with family traditions of union membership and collectivism. Until the late 1980s, most Irish nurses came from rural areas and many left the health service when they got married and formed a family. For example, the Working Party on General Nursing (1980) reported that the majority of respondents to a

[166] Female Staff Nurse (25 years of age) in *Voluntary Hospital*, Interview 1-5.
[167] Female Staff Nurse (28 years of age) in *Voluntary Hospital*, Interview 1-6.
[168] Female Ward Sister (32 years of age) and union representative in *Voluntary Hospital*, Interview 1-7.

survey of 1,364 nurses carried out in 1978 were from rural areas and only 29 per cent were over 40 years of age. In the workplace survey carried out by the author, nurses were asked whether their family has a 'union tradition'. Although just 26 per cent of nurses have this kind of family background, this rises to 30 per cent amongst nurses under 30 years of age and reaches 40 per cent amongst student nurses. In contrast, only 27 per cent of Italian student nurses come from families with a union tradition, which suggests that the nursing category may be becoming more 'middle class' as it becomes increasingly 'feminised' in Italy (see Chapter Five), whilst the opposite is the case in Ireland.

Although union militancy is a new phenomenon amongst Irish nurses, Italian nurses have a long history of militancy. For example, there was a major revolt by hospital workers in 1978, and this was one of the formative experiences of Neapolitan nurses who are now in their mid-forties. As I noted in Chapter Five, the majority of the workforce of the case study hospitals falls into this category. The following extract provides an example of the outlook of many Italian nurses, and indicates their willingness to consider industrial action:

> *I'm a bit of a rebel: I would get everybody together and I would block the hospital completely – a wildcat strike – until the leadership// [Researcher: //listened seriously. Has similar action taken place in the past?] Yes, yes, and it still happens. … Listen, there has been loads of industrial action, but I repeat, it was more likely to happen because a contract had expired, for example. … Where money is involved, the employees of this hospital have always been willing to go on strike, whereas I believe that we should take strike action in order to give the patients something extra, in order to provide a decent service.*[169]

Once again, it is interesting to note how Italian nurses, like their Irish counterparts, link 'patient care' grievances with the representative relationship and look to collective action as a means of addressing problems in relation to this category of grievance.

[169] Male Ward Sister (59 years of age) in *Presidio*, Interview 3-4.

It is useful to examine whether there are gender or age differences in the orientations of Irish and Italian nurses towards their unions and their jobs, as such differences can often provide an indication of the extent and dynamics of change in relation to union membership and participation. To this end, I will analyse the responses of nurses in the case study hospitals to a series of attitudinal questions that measure 'militancy', 'vocationalism' and 'professionalisation' (see Table 6.4 below).

A number of interesting comparisons and contrasts emerge from the percentages reported in this table. Firstly, it is apparent that both Irish and Italian nurses share an overwhelmingly negative view of their status in society (Question 1) and their current work autonomy (Question 7). They have similar feelings about the benefits or drawbacks of adopting a conflictual attitude towards health service managers (Question 6). Irish nurses are less favourable than Italian nurses in their responses to the key question about industrial action (Question 3): whereas 59 per cent of Italian nurses are in agreement with the statement that "A nurse should not take industrial action which may have a negative impact on patient care", this applies to only 40 per cent of Irish nurses. This undoubtedly reflects the increased militancy of the Irish nurses prior to the 1999 strike and indicates a hardening in nurses' attitudes in relation to the likely consequences of industrial action. Whereas 46 per cent of Italian nurses believe that "Nurses will not get a fair deal from the government until they are prepared to fight for it", this applies to no less than 79 per cent of Irish nurses. These results are surprising, given the traditional militancy of Italian nurses and relative 'docility' of their Irish counterparts, and require further scrutiny and analysis.

Table 6.3 Indicators of Nurses' Work Orientations

Text of Question	Dimension	Percentage of Irish nurses who 'agree or 'strongly agree'	Percentage of Italian nurses who 'agree' or 'strongly agree'
1. Nurses' expertise and experience are given the respect they deserve by society	*Social Status*	*15%*	*6%*
2. Nurses will not get a fair deal from the government until they are prepared to fight for it	*Militancy*	*79%*	*46%*
3. A nurse should not take industrial action which may have a negative impact on patient care	*Vocationalism*	*40%*	*59%*
4. The nursing profession needs its own representative organisations in order to defend its interests	*Sectionalism*	*90%*	*69%*
5. I decided to become a nurse because I wanted to help the sick and injured	*Vocationalism*	*51%*	*44%*
6. Nurses do not gain by adopting a conflictual attitude towards health service managers	*Militancy*	*47%*	*40%*
7. Nurses have sufficient autonomy in the performance of their work	*Professional Autonomy*	*10%*	*20%*
8. I decided to become a nurse for economic/ employment reasons	*Vocationalism*	*11%*	*45%*
9. Nurse managers/Matrons should not be allowed to join general nursing trade unions	*Militancy*	*7%*	*51%*

The proportion of Italian nurses who "decided to become a nurse for economic/employment reasons" is much larger (45%) than amongst Irish nurses (just 11%). This confirms the observation that I made in Chapter Five in relation to nurses' motives for choosing this profession in the context of labour market constraints. Finally, whereas 51 per cent of Italian respondents are in agreement with the proposition that "Nurse managers/Matrons should not be allowed to join general nursing trade unions",

this applies to just 7 per cent of Irish respondents, underlining the more deferential and collegiate attitudes of Irish nurses in relation to their Nurse Managers.

If we sum the responses to questions 2, 6 and 9 to form an index of 'attitudinal militancy', and the responses to questions 3, 5 and 8 to form a measure of 'vocationalist orientations', we can explore differences in nurses' orientations by age and gender[170]. Tables 6.4 and 6.5 report the results of this analysis for the Irish and the Italian samples. The figures in the table represent the mean scores for each group, making the appropriate adjustments to the scoring of responses in order to account for the 'negative' and 'positive' wording of the questions. Higher scores represent a stronger orientation towards militancy or vocationalism; the minimum score possible is 3 and the maximum 21.

Table 6.4 Composite Indices of Nurses' Work Orientations by Gender

Scale	Ireland		Italy	
	Female	Male	Female	Male
Attitudinal Militancy	*15.1*	*19.5*	*12.6*	*12.9*
Vocationalist Orientation	*15.2*	*10.8*	*15.1*	*12.9*
Respondents	*251*	*4*	*145*	*323*

Table 6.5 Composite Indices of Nurses' Work Orientations by Age

Scale	Ireland				Italy			
	<30	30-39	40-49	50+	<30	30-39	40-49	50+
Attitudinal Militancy	*15.0*	*15.6*	*15.4*	*13.8*	*12.6*	*12.7*	*12.8*	*13.1*
Vocationalist Orientation	*15.0*	*14.3*	*16.8*	*18.6*	*14.4*	*14.4*	*12.5*	*14.4*
Respondents	*142*	*74*	*21*	*13*	*20*	*148*	*212*	*78*

[170] The value of coefficient alpha for these two scales is .56 and .31 (Ireland) and .51 and .45 respectively (Italy). Although these values are rather low, it must be remembered that alpha is sensitive to the number of items included in a scale, and we have just three indicators in each of these measures.

In terms of gender differences, male nurses in Ireland appear to be more militant and less vocationalist than their female colleagues – although the sample size is just 4 and it would obviously be hazardous to generalise from such a small base. Male nurses in Italy are slightly more militant and considerably less vocationalist in their orientation towards nursing than their female colleagues. Female nurses in Ireland show a *higher* level of attitudinal militancy than female nurses in Italy, although their scores on the other two dimensions are similar, and this confirms the observation made earlier in relation to Table 6.3.

As far as age differences are concerned, Table 6.5 indicates that in Ireland, attitudinal militancy is considerably lower amongst the oldest cohort of nurses, whereas this tends to increase with age in Italy. In fact, a marked increase in vocationalist orientations with age is observed in Ireland, reinforcing the observations that I made earlier about the different background and outlook of younger cohorts. There is a considerable 'dip' in vocationalism amongst Italian nurses aged 40-49, and this clearly corresponds to the cohort of nurses who entered the Neapolitan hospitals following the movement of the 'organised unemployed' in the 1970s (see Chapter Five).

Irish Nurses' Evaluations of Their Union Representatives

Turning now to union representation in the Irish hospitals, it is important to stress that there is no evidence of union clientelism or corruption in this context. Although political clientelism has had a considerable influence on health service management in this country (see Chapter Four), this has never been a dominant influence, nor has it involved the cooptation of workplace union representatives. In fact, Irish nurses express considerable satisfaction with their representatives, contrasting the current situation of activism with the situation that prevailed in the past, which was characterised by a lack of information and participation at local level:

> *That's another thing you'd notice now, any meetings and that, there's always notices up all over the place and people want to go to them. ... Like I always let the girls go up there from xxx ward, two or three of them. [Researcher: And do they*

then feed the thing, feed the information back?] They come back with the information, yeah. [Researcher: So that's... Yeah. That's new in terms of just this year or how recent is that?] Probably in the last two years I'd say.[171]

As I mentioned in Chapter Five, industrial relations in the Irish health service has tended, in recent years, to follow the 'pressure cooker' model, which is characterised by periodic outbursts of militancy, but by relatively weak forms of local union organisation and a high level of centralisation. In fact, Irish nurses are often reluctant to get directly involved in their union:

You see, people tend to give out to each other and, you know, a lot of people don't actually do anything about it. People have to get together to do something. One of the reasons why it doesn't happen here, a lot of the appointments here were, a lot of the Ward Sisters would have been trained in this hospital so they don't like to... They would have that ethos too, that we're like here to... not rock the boat ... and accept it and 'nothing can be done about it anyway'.[172]

The occupational culture of Irish nursing and the 'ethos' of the Public Voluntary hospitals continues to have a considerable influence on nurses' attitudes towards union organisation. In conjunction with the individualistic orientation that I described earlier, a reluctance to 'rock the boat' and a sense of deference in relation to the occupational hierarchy has tended to reduce participation levels. As a result, grievances tend to 'accumulate' at local level, until nurses are so frustrated that they are induced to adopt a more confrontational stance:

In one hospital – the Matron has gone now – she said: "I will NOT supervise and stand over nurses who do not look like nurses, and as long as I am the Matron here you will wear hats". But in that hospital, the nurses then turned around and said "we voted, democratic decision, we are doing it as of such a date". But to get nurses to get to that level requires years of intimidation and frustration built up over other reasons that they will stand up for something as incidental as wearing a hat.[173]

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[171] Female Ward Sister (42 years of age) in *Voluntary Hospital*, Interview 1-9.
[172] Female Ward Sister (32 years of age) in *Voluntary Hospital*, Interview 1-7.
[173] Female Industrial Relations Officer from the INO, Interview U-10.

Italian Nurses' Evaluations of Their Union Representatives

In order to understand the current situation of the unions in the health service in Southern Italy, it is important to appreciate the disillusionment of nurses with the existing unions:

> *By now the unions, at a general level – but above all at workplace level – do everything but defend the interests of the workers. [Researcher: I don't understand.] They do everything EXCEPT look out for the interests of the workers.*[174]

Many Neapolitan nurses are sceptical about the representative capacities of their unions and suspicious about the motives of their representatives. This is due to their perceived lack of independence from management, the involvement of representatives in corruption scandals at the beginning of the 1990s, the unions' adoption of a clientelistic logic of recruitment and the arrogant and overbearing behaviour of some of the most powerful representatives. The following description, provided by a recently-elected union representative, is illustrative of the nature of the relationship between many union representatives and hospital managers:

> *You see now... I am starting to understand certain things – although I have to admit that you only get to know what they want you to know. For example, meetings between union representatives and management should be by invitation. However, you regularly see the other union representatives, during the morning, going 'to confession' as I put it! In other words, they first call in on the nurse managers, then they go to the* Direttore Sanitario... *Therefore you have this underhand approach, these strategies...*[175]

One of the most common mechanisms leading to the incorporation of union representatives is their promotion to a supervisory grade. This is also the most visible aspect of union incorporation: it is sufficient to follow the career progression of union

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[174] Male Staff Nurse (36 years of age) in *Azienda*, Interview 2-11.
[175] Male nurse (45 years of age) and union representative in *Presidio*, Interview 3-2.

representatives following their election in order to detect this influence, as the following extract shows:

> *The current CGIL representative here is a nurse manager who became a manager even though he doesn't have the necessary qualifications – he is technically still a Ward Sister. Many nurse managers... (pause) They are nearly all union representatives. (pause) Listen, I don't challenge the union, I think that the union... if it weren't for the unions, there wouldn't be freedom today, there wouldn't be freedom for many of us. The union is a fantastic institution – marvellous. As an institution it has an indispensable role in defending the workers. However, the culture of unionism has undoubtedly suffered a degeneration. Basically the union has now become almost like management, it has merged seamlessly with the administration both at local and national level.*[176]

Undoubtedly, the involvement of certain union representatives in bribe-taking is one of the main factors underlying nurses' current antipathy towards the unions. A nurse in *Azienda* provided the following account of union corruption:

> *I used to say: "I'm a worker and I want to be represented by a union" – even though I had my doubts, and I didn't exactly believe what the union said. Then I saw that these things were confirmed. My boss, in my union – xxx – is now in jail, because he had been sharing bribes with the ex-President. It's been in the newspapers, there are legal proceedings – the trial is coming up. That's just to give you an idea – they were dividing up the money, and the most basic materials were lacking…*[177]

Another nurse, currently a union representative for the CGIL, describes the nature of the previous system of bribery:

> *…it was limited to a couple of people, because with the old system, basically there was the Secretary, there were small groups of comrades who controlled everything and who participated in negotiations. They were involved in negotiations over a*

[176] Male Staff Nurse (43 years of age) in *Emergency Block*, Interview 4-2.

> *series of things, from tenders for the supply of materials, the privatisation of certain sectors, the closure of the laundry... Basically everything that could be contracted out in this hospital was sold off with the approval of certain unions. Remember that this phenomenon involved above all these three union organisations (i.e. CGIL, CISL and UIL) for the simple reason that these three unions together accounted for something like 60 per cent of members, therefore they had considerable bargaining power.*[178]

As I noted earlier, Italian nurses have a strong belief in the value of unions and feel that union representation is important within the workplace. Many nurses remained within the historical union confederations during the 1980s, continuing to believe that these unions provided the best form of collective representation. However, bribery scandals, political reform and the consolidation of tripartite bargaining at national level triggered a process of fragmentation during the early 1990s, and the union confederations began to haemorrhage. Initially, the main beneficiaries of this process were the traditional 'autonomous' unions, which presented themselves as an apolitical, independent and 'untainted' force for change. Within a relatively short period of time, however, many nurses left the autonomous unions in disillusionment with their narrow outlook and opportunism, and only a minority went on to join category-based or rank-and-file organisations.

Table 6.6 below provides an indication of the past union affiliations of Italian nurses and shows that many current members of CISL, UIL, the traditional autonomous unions, rank-and-file unions and professional/category unions were previously CGIL members. Table B.1 (in Appendix B) also shows that many current non-members are past members of either the CGIL or the UIL, or both. Other nurses followed a more complicated trajectory, passing through the autonomous unions or rank-and-file unions on their way to the category-based FAPAS union, for example. Table 6.7 reports the length of time that Italian nurses have been members of their current union and provides further evidence for the realignment that occurred during the 1990s. Whereas 65.7 per cent of CGIL members have been in this union for 10 years or more, this applies to just

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[177] Male Staff Nurse (49 years of age) in *Azienda*, Interview 2-6.
[178] Male Staff Nurse (39 years of age) and CGIL representative in *Azienda*, Interview 2-24.

37.2 per cent of UIL members and 23.4 per cent of CISL members. The percentage falls to practically zero for all other unions. For example, all current members of a professional or category-based union have joined within the last five years.

Table 6.6 Past and Present Union Membership of Italian Nurses[179]

	Past Union						
Current Union	CGIL	CISL	UIL	Trad. Auton.	Rank-and-File	Prof./ Categ.	Total
CGIL	*47.9%*	*11.4%*	*3.8%*	*0.0%*	*0.0%*	*0.0%*	*28.4%*
CISL	*4.1%*	*57.1%*	*7.7%*	*15.4%*	*0.0%*	*0.0%*	*11.9%*
UIL	*11.6%*	*0.0%*	*57.7%*	*7.7%*	*0.0%*	*0.0%*	*17.9%*
Traditional Autonomous	*20.6%*	*22.9%*	*7.7%*	*69.2%*	*0.0%*	*0.0%*	*20.1%*
Rank-&-File	*2.1%*	*2.9%*	*3.8%*	*7.7%*	*75%*	*0.0%*	*4.9%*
Professional/ Category	*13.7%*	*5.7%*	*19.2%*	*0.0%*	*25%*	*100.0%*	*16.8%*
Respondents	*146*	*35*	*52*	*16*	*8*	*11*	*268*

Table 6.7 Length of Time in Current Union for Italian Nurses

	Current Union						
Time in Union	CGIL	CISL	UIL	Trad. Auton.	Rank-and-File	Prof./ Categ.	Total
< 5 years	*19.4%*	*30.0%*	*44.2%*	*94.2%*	*90.9%*	*100.0%*	*58.1%*
5-10 years	*14.9%*	*46.7%*	*18.6%*	*1.9%*	*9.1%*	*0.0%*	*13.8%*
10-20 years	*40.3%*	*16.7%*	*18.6%*	*3.8%*	*0.0%*	*0.0%*	*17.1%*
> 20 years	*25.4%*	*6.7%*	*18.6%*	*0.0%*	*0.0%*	*0.0%*	*11.0%*
Respondents	*67*	*30*	*43*	*52*	*11*	*43*	*246*

Clientelistic forms of recruitment and interest representation also played an important role in the degeneration of local union sections in Naples during the 1980s and 1990s. In order to understand this phenomenon, it is worth recalling the discussion of political clientelism provided in Chapter Four. Both political and union clientelism involve an

asymmetrical, instrumental dyadic relationship in which a higher-status partner provides resources or benefits in return for the allegiance and support of a client. Whereas this support takes an electoral form in the case of political clientelism, it involves union membership in the case of the unions. Although the political patron has direct access to resources and power by virtue of his or her office, the union patron relies on managers, administrators or other local actors in order to access resources. Thus, union clientelism tends to go hand-in-hand with the incorporation of union representatives.

As I mentioned in Chapter Four, union clientelism in Naples is based primarily on the ability of union representatives to influence overtime, job mobility and work roles. The difficulties involved in changing wards or gaining a promotion when following normal procedures induces many nurses to look to the unions as a means of obtaining an individual solution to their problems. Although this ensures that a certain number of nurses continue to join the unions, it has merely increased the disaffection of nurses in general with their union representatives. Indeed, nurses who join a union as a means of resolving an individual problem frequently criticise this system of representation. One interviewee cancelled his subscription to a confederal union after obtaining a transfer for his wife from another hospital, and even refused to greet the union representative who had secured the transfer. If the unions did their job, he argued, he would not need to approach representatives 'for a favour'[180].

The final factor underlying nurses' negative evaluations of their union representatives in Naples is their arrogant behaviour:

> *Listen, we have nice gardens here, and you used to find the union representatives of the CGIL, the CISL and the UIL in the gardens. [Researcher: In the gardens?] In the gardens – they used to negotiate in the gardens. [Researcher: What were they doing in the gardens?] Well, you know, probably the CGIL started meeting in the gardens and the CISL just copied them, or vice versa. [Researcher: All together or were there three different groups?] No, they used to discuss, negotiate, meet up or whatever. And in fact, if you heard somebody ask for the union representatives:*

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[179] The percentages in this table relate to past union affiliations; for example, only 47.9% of nurses who have ever been members of the CGIL are still in this union.
[180] This account was provided on a confidential basis by a Staff Nurse in *Azienda*.

"Sure they're having a walk in the gardens!" Even though they had a union office... But anyway that was the custom, and people in the hospital were used to having union reps who never worked, who just hung around.[181]

By avoiding work, union representatives could demonstrate how powerful they were, even to the point of avoiding work and everyday work discipline:

For them it was almost humiliating to put on a uniform. They would hide their uniforms. I'm not a military freak, or a uniform fetishist, but they weren't defending my work... ... [Researcher: //They hardly worked?] They didn't work at all! And not working meant that they could show that 'they were a big cheese in the hospital', in relation to their colleagues and any relatives or friends who came from outside. Because when they arrived they could say: "I don't work, I'm a union rep, I'M in charge here".[182]

Naturally, we must ask why managers were prepared to accept this situation, and there are three main reasons for this. Firstly, the ability of the unions to shut down the hospital and to obstruct managers' plans was a key factor at the beginning. The unions had hundreds if not thousands of members in each of the case study hospitals. Secondly, because of the past weakness of managers, who typically owed their nomination to a political party, the unions were often able to impose their wishes, as one representative recalls:

Before, we used to enter the President's office (i.e. President of the Board of Management of the hospital) when we were in disagreement – and a few times I even overturned his desk – because he was a political figure, and therefore we could do ANYTHING. ... Even if I threatened him, we would remain on first-name terms. ... Also because there used to be a party relationship, we used to see each other at conferences, and therefore there were political links there, which were also exploited here in the hospital.[183]

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[181] Female union representative in *Azienda*, Interview U-1.
[182] Male Staff Nurse (43 years of age) and union representative in *Azienda*, Interview 2-21.

Finally, managers themselves had a vested interest in cultivating their relationship with union representatives. As became clear during the corruption trials of the early 1990s, managers and union representatives were, at times, complicit in bribery schemes in which contracts were allocated to those firms which paid the largest bribes. This clearly provided a material basis for the 'irregular' relationship between representatives and managers; even where union structures had not degenerated to this point, managers had an overwhelming interest in avoiding industrial conflict, as their role was to generate consensus and to gather votes (see Chapter Four).

In terms of the earlier discussion of union representation, it is apparent that due to the social embeddedness of the 'representative relationship', representatives may in certain circumstances be subject to tendencies towards corruption and clientelism as well as routinisation. Compared with these forms of degeneration, the progressive elements of 'bureaucratised' union organisation come to the fore, namely an emphasis on legality, procedure and formal processes of decision-making. In this sense, the term 'bureaucracy' acquires more positive overtones (cf. du Gay, 1994). Moreover, a degree of formalisation of roles may be necessary in order to ensure the survival of union organisations during periods when union struggles are at a low ebb. Thus, when applied to the study of union organisation, the concept of 'bureaucratisation' does not exclude the possibility of recognising the positive attributes of institutionalised union practices.

Whereas the recent history of union representation in the Neapolitan hospitals bears out the possibility of removing representatives with vested interests, it also testifies to the difficulties that union members face in overcoming societal forces originating outside the representative relationship. One of the obstacles to union renewal in Italy – at least until the mid-1990s – was the vagueness of union regulations and the lack of clarity in relation to assemblies, votes, elections, sanctions and responsibilities (Accornero, 1992: 155). Until legislation on workplace union representation was approved in the middle of the decade, it was very difficult for union members to appeal to existing democratic procedures in order to remove ineffective representatives. This informality may be

[183] Male Staff Nurse (43 years of age) and union representative in *Azienda*, Interview 2-21.

attributed to the lack of legal regulations[184], to union leaders' lack of concern for the quality of local union structures during the 1980s and to the 'democratic deficit' of the confederal unions[185]. This underlines the importance of studying the representative union relationship in the context of the other social relationships in which hospital workers are involved. In Southern Italy, tendencies towards 'resistance' are frequently diverted into an individualistic battle for survival due to demoralisation, scepticism about the prospects of collective action and the inability of managers to resolve even the most basic grievances (see Chapter Four).

Thus, when we consider the structure of workplace representation, the nature of the representative relationship and nurses' evaluations of their representatives, there is a very stark contrast between the situation in the Irish and Italian case study hospitals. As I showed in earlier chapters, common pressures in relation to health reform and strategic management have produced quite similar patterns of organisational behaviour across these two national contexts. The structure and content of national union representation are also comparable, although the representative relationship at workplace level retains a strong element of local specificity due to its social context and due to the influence of organisational, cultural and political traditions within the union movement.

Irish Nurses' Expectations in Relation to Union Representation

Most Irish nurses do not have precise expectations or aspirations in relation to workplace union representation, as they have very little direct experience of local organisation:

[184] Article 39 of the Italian Constitution, which was never implemented via legislation, would have forced unions to register and to provide a public guarantee of their internal democratic procedures (Garonna & Pisani, 1988).

[185] In relation to union democracy, I provided a number of examples in Chapter Three of the reluctance of CISL and UIL to consult their members on key aspects of union policy during the early 1990s and I showed that the CGIL vacillated on this issue on a number of crucial occasions. For example, CGIL leaders have consistently rejected calls for the election of national and regional union officials by members.

[Researcher: Do you know who the representatives would be for the INO?] Xxx in Outpatients – I mean there's a couple of them. I'd know the faces, and I'd know where to go and find them – there's two girls in Theatre – but not the names. [Researcher: So there are a few different people basically. How do you feel about what they are doing at the local level to represent nurses?] I think they are doing the very best that they can. … I think morale is very low in the hospital anyway. I'm not blaming the hospital, but the morale about, just nurses and nursing in general and the hospital and stuff, so I think they have a tough job trying to get people motivated. I don't think it's easy.[186]

Nurses who have worked in hospitals with stronger local union structures often take these experiences as a yardstick:

I think in THAT hospital my experience of them was that everything was taken care of by the union. Things were nipped in the bud, you didn't have to go to them with anything because they were out there. … You know, you'd never have to go to them with a grievance because they would usually spot it themselves, and didn't allow things to escalate.[187]

The survey data reveal that a sizable number of nurses in the Irish case study hospital have prior experience of other unions, as Table 6.8 below indicates, and this represents an important vehicle for the diffusion of new models of representation:

…when I go round on the wards with notices about meetings and that, I get a mixture of reactions, from "Oh God, the INO" (critical tone), you know, to "Oh great, great!". And the people who tend to say "oh great!" are people who have worked abroad and they know what they're about and they know how to use the union, you know. They know exactly how to use it and they will get involved, they will attend the meetings and they know that they have to do that. Whereas other people just expect the union to work magic for them without them ever having to do a thing, you know.[188]

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[186] Female Staff Nurse (31 years of age) in *Voluntary Hospital*, Interview 1-2.
[187] Female Ward Sister (32 years of age) in *Voluntary Hospital*, Interview 1-7.
[188] Female Staff Nurse (34 years of age) and INO representative in *Voluntary Hospital*, Interview 1-10.

Table 6.8 Past Union Affiliations of Irish Nurses

Union	Frequency	Valid %
INO	*27*	*39.1%*
SIPTU	*10*	*14.5%*
PNA	*2*	*2.9%*
RCN	*27*	*39.1%*
Other	*3*	*4.3%*
Missing	*191*	-
Total	*260*	*100.0%*

The nurse speaking in the extract quoted above went on to become a union representative herself. This is her response when asked about her experience as a representative after the first few months:

> *[Researcher: How has the experience been, up until now? I mean, you've had a few months.] Awful! (heart-felt) I mean it's an awful place to be in because whenever there are any difficulties people now see that there is a rep, that there is a place where they can bring their grievance to. And then they formalise it once it is brought to a union, where it could be sorted out elsewhere. I have had two meetings with management now with regard to staffing levels and there was a lot of difficulty with... I mean the Matron would have said "I have never had to deal with the union like this before".*[189]

It is evident that nurses in the Irish case study hospital view local union representatives as those who 'take the issues to Nursing Management', who provide information from union Head Office and organise local meetings in order to discuss important national campaigns or issues. Nevertheless, there is evidence that a 'new breed' of representative has emerged in recent years, in the context of the increased militancy of the nursing profession and localised action over staffing levels and overcrowding (I will return to this point in the following section).

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[189] Female Ward Sister (32 years of age) in *Voluntary Hospital*, Interview 1-7.

In contrast with Naples, union representatives in the Irish case study hospital are critical *of their own members* for not taking a greater interest in the union. Nevertheless, during the run-up to the threatened strike in 1997 and during the nurses' strike in 1999, members began to place more concrete demands on their representatives and to develop a deeper understanding of their role. At that point, the demands of Staff Nurses for greater representation came to the fore, and criticism was voiced in relation to the dominance of Ward Sisters and Unit Nursing Officers within the Strike Committee. However, individual Staff Nurses appeared to be reluctant to take on a greater role, perhaps due to the presence of Nurse Managers within the Committee:

> *Well, there was some controversy over how it was selected. Two months ago, I rang xxx in the INO, and I said 'who are the INO Reps in the hospital?'. So he said 'Well you're one'. And I said OK, yeah so I'm one… … there were two in Theatre and there were two in the School. There was no Staff Nurse INO Representative. … So an invitation went to EVERYBODY, OK? We got twelve people, we got two Staff Nurses... OK? A week later, rumours were FLYING around, running rife, saying that people were 'hand-picked' for the Committee, there wasn't enough Staff Nurses on the Committee... So the Strike Committee took this back, and we felt 'OK, so we'll accommodate more people'. We sent one of the two Staff Nurses around to get two more Staff Nurses. It was two days before we got one, and three days before we got another.*[190]

Italian Nurses' Expectations in Relation to Union Representation

In the encounter between nurses' ideals and the reality of existing union structures, a fertile area of inquiry opens up. In Naples, various aspects of union representation are identified by union members as desirable. It is argued, for example, that workplace union representatives must actually work alongside other union members, a point that is emphasised by a large number of interviewees:

[190] Female Ward Sister (35 years of age) and INO representative in *Voluntary Hospital*, Interview 1-8.

I have always argued that the union representatives should give back what they have robbed from us. Here – in the middle of us – that's the way to bring them down to size. You can't get away with being a union representative and only that … You have to start by getting stuck in, getting burnt by the problems, then you can tackle them. … Second Interviewee: The union representative, in order to carry out his or her job, in the very moment in which he or she represents the union, must remain in the ward. They HAVE TO work the way their members work, and that is the only way that they can understand their grievances.[191]

This extract emphasises the relevance of work grievances to workplace union representation, and also underlines the nascent sectionalism that characterises workplace unionism. Clearly, if union representatives must work alongside nurses, then they must also be nurses. This clashes, however, with the second element that many nurses aspire towards: a collectivist form of representation:

You need the general unions, because they can take up more or less all the day-to-day problems, whatever they may be: economic, environmental, to do with surveillance, forcing the managers to fulfil their obligations and so on. They enter into conflict with management, and it is right that there should be conflict, because it's useless... When you're dealing with management it's difficult to resolve things in an amicable way. Managers look after their own interests, and the unions must be conflictual in order to achieve their objectives. There's not much that you can do about that. On the contrary, when the unions have not been conflictual, they have been so completely subordinate that subsequently they merged into one thing, the administration and the unions, to the workers' cost.[192]

Thirdly, Italian nurses insist on the democratic election of representatives so that they can choose 'trustworthy' individuals. Up until now, the procedures for electing representatives have been rather vague in many hospitals and the interval between elections has been excessive: "We would like to renew the union, but unfortunately the electoral mechanisms within the union are highly, how should I say… strange. They don't allow for substitution. … The union representatives can defend their… They can

[191] Two Male Staff Nurses (41 and 52 years of age) in *Azienda*, Interview 2-18, 2-19.

ensure their own survival"[193]. Fourthly, the Italian interviewees draw attention to the importance of selecting union representatives who have an understanding of industrial relations and who have the preparation necessary in order to enter into discussions with management. Fifthly, nurses emphasise that union representatives should have the interests of workers at heart and should not have vested interests. Finally, in a more general vein, a number of nurses stress the need to rationalise the structure of representation and to overcome the fragmentation that characterises the current situation:

> *...you have to have that kind of bargaining power, and it certainly doesn't materialise if I represent five people and another person represents eight and another person nine. The logic should be based on common interests, all of us should work towards developing a strong bargaining position in relation to management. Otherwise, as they say in Naples, we will take blows left right and centre. We can go in there alright, and they will listen to us, but then they will just do whatever they want. Therefore the unions need to be reorganised in these terms, from the perspective of overall union organisation, from the perspective of union CONSCIOUSNESS, because what is lacking in this hospital, even though people are fairly politicised, is precisely a sense of union consciousness.*[194]

The final aspect of the representative relationship that is emphasised by Italian nurses is the need for structures that encourage participation by union members:

> *Previously (i.e. in the 1970s), there was a stronger relationship between the base and the union representatives, there was a constant, continuous osmosis, because they communicated more often, because there were frequent assemblies, because the workers participated more, because their needs were... ... Instead, today there is a dislocation and it is that dislocation that does the most harm.*[195]

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[192] Male Staff Nurse (43 years of age) in *Azienda*, Interview 2-13.
[193] Male Staff Nurse (43 years of age), in *Emergency Block*, Interview 4-2.
[194] Male Staff Nurse (42 years of age) in *Azienda*, Interview 2-5.
[195] Male Ward Sister (52 years of age) in *Azienda*, Interview 2-23.

These various elements – representatives who work, who have a good understanding of industrial relations, who are closely linked to a specific area of the hospital, who have a commitment to improving the situation of all workers, who encourage participation and are accountable to their members – may be traced to the past experiences of Italian nurses with different types of union representation. In particular, the model of the *Consigli di fabbrica* during the 'hot autumn' (see Chapter Three) continues to exercise an influence on nurses' ideas about workplace union representation. The presence of strong models of workplace democracy such as this within the political tradition of the union movement enables nurses to develop a relatively sophisticated critique of existing arrangements.

Patient Care and the Representative Relationship

One of the specificities of nursing work is the 'therapeutic relationship' between nurses and their patients, which generates a strong commitment amongst nurses to the well-being of their patients. This inevitably has an impact on the representative relationship, as nurses aspire towards a form of representation that not only defends their wages and conditions, but one that also safeguards the interests of their patients and valorises the therapeutic relationship. As I noted in Chapter Five, nurses frequently treat obstacles to patient care as if they formed part of *their own* grievances. This means that grievances relating to patient care are transmitted to the sphere of union representation in the form of demands for specific improvements in the organisation and funding of the hospital, although union representatives are often unsure about how to effectively pursue these issues.

Due to their close relationship with patients, therefore, nurses frequently take up issues related to the quality of patient care and articulate these as nursing grievances. For example, the use of stretcher beds, inequalities in the way patients are treated and the absence of suitable beds, monitors and other equipment are highlighted by nurses. The following extract, from an interview with an Italian nurse, provides an example of this overlap between union action, on the one hand, and grievances related to patient care, on the other (in this case the issue is the use of oxygen canisters with patients with respiratory difficulties):

We have done everything, we have written letters, we have protested … because all you need is a spark. Second Interviewee: …emphasising the dangers for patients in having these oxygen canisters by the patient's bedside. But it is YEARS (pause). Nothing… [Researcher: And have the unions tried to do something about it?] Second Interviewee: Even the unions have denounced it several times.[196]

Other Italian nurses point out that improvements in patient care have often been due to the intervention of the unions, and that industrial action was necessary in order to force management to provide the necessary materials and resources:

Just think that until three or four years ago we had to take action in order to have disposable gloves! Until seven or eight years ago we didn't even have disposable syringes! (pause) Just picture it, glass syringes… And these battles were fought by the workers and led by the unions in order to produce a small improvement in the quality of care.[197]

A further consequence of nurses' commitment to patient care is that when they are considering industrial action, the need to avoid harming patients who are seriously ill is paramount:

Yesterday our Strike Committee met with hospital management, and they were amazed at how... how giving we were of our services. … We have insisted on an uninterrupted Oncology service.[198]

At the time of the threatened strike action in 1997, a large number of Irish nurses expressed their reservations about reducing service levels and inconveniencing patients:

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[196] Two male Staff Nurses (46 and 43 years of age) in *Azienda*, Interview 2-13, 2-14.
[197] Male Staff Nurse (45 years of age) and union representative in *Presidio*, Interview 3-2.
[198] Female Ward Sister (35 years of age) in *Voluntary Hospital*, Interview 1-8.

[Researcher: ...you would have thought twice about actually going on strike?] Yeah. ... I mean at the end I had voted against walking out. It just goes against EVERYTHING that you stand for as a nurse, like to actually walk out on the patients.[199]

[Researcher: Describe your dilemma.] Well I don't believe that people should go on strike and it's a shame... You know, it's the last resort and it's probably the only solution a lot of times but... [Researcher: You really wouldn't want to do it?] I didn't want to do it because I felt it would be the patients that were suffering but the only reason that I joined the INO is because if I wasn't a member, I would have had to stay here and work and I wouldn't have been in solidarity with my colleagues really.[200]

Similarly, many Italian nurses view their responsibility for patient care as an obstacle to taking effective strike action:

At any rate this type of work imposes limits, you can't just go out on strike. If you go on strike you still have to continue to provide nursing care – and quite rightly so. So your struggles don't even have an impact, particularly in a state where very little consideration is given to the health of the citizens – otherwise the hospitals would function differently.[201]

Finally, nurses' commitment to the well-being of their patients means that they have generally welcomed those aspects of managerialism and organisational change that improve the coordination of services, reduce waiting lists and improve the quality of care, even where these aspects of health service rationalisation have involved an increase in workloads. For example, in the Dublin case study hospital, nurses welcomed the introduction of a system of 'team nursing' in one group of wards, as this ensured greater continuity in nursing care. But this was at the cost of longer shifts and a greater intensity of work.

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[199] Female Ward Sister (32 years of age) and union representative in *Voluntary Hospital*, Interview 1-7.
[200] Female Ward Sister (42 years of age) in *Voluntary Hospital*, Interview 1-9.

As I showed in Chapter Four, the emergence of an autonomous and strategic management function in *Azienda* led to a number of changes in the organisation of the hospital that led to an acceleration in patient throughput. Rather than resisting this development, most nurses welcomed the benefits that this yielded for patients:

> *...now there is a tendency towards reducing the length of stay, because there is the process of* aziendalizzazione*, the DRG system, I don't know if you know... Therefore there is a tendency to reduce these. It's a good thing because it produces savings and the patient doesn't have to stay in hospital more than is necessary. ... Second Interviewee: It's a positive thing as far as patients are concerned. [Researcher: And for the nurses?] Even for the nurses it's a positive thing, because at any rate you can see a benefit in terms of patient care, the patient is no longer abandoned here for 10 days or a month ... even though it increases nurses' workloads.*[202]

Participation in Workplace Unionism

As I noted earlier, participation at local level provides a counterweight to the incorporation and routinisation of union representation and enables nurses to influence the selection and behaviour of workplace representatives. An initial impression of union participation rates in the case study hospitals is provided by two questions included in the survey. These questions inquired about attendance at union meetings and whether there is a union representative at workplace level (see Figure 6.3).

In Naples, a restricted group of active union members (perhaps representing 10-20 per cent of members) exists alongside a larger pool of relatively inactive members. As far as the Irish situation is concerned, the survey reveals a more passive picture. Whereas in the Italian hospitals, a minority (35%) of nurses do not attend union meetings, this applies to almost two-thirds (65%) of Irish nurses. Indeed, almost one-fifth of unionised nurses in the Irish hospital do not know whether they have a workplace union representative, indicating the weakness of union organisation at local level. In contrast,

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[201] Male Staff Nurse (48 years of age) in *Azienda*, Interview 2-16.

it is revealing that 93 per cent of Neapolitan union members gave a positive response when asked whether there was a representative of their union in the hospital.

Figure 6.3 Frequency of Attendance at Union Meetings

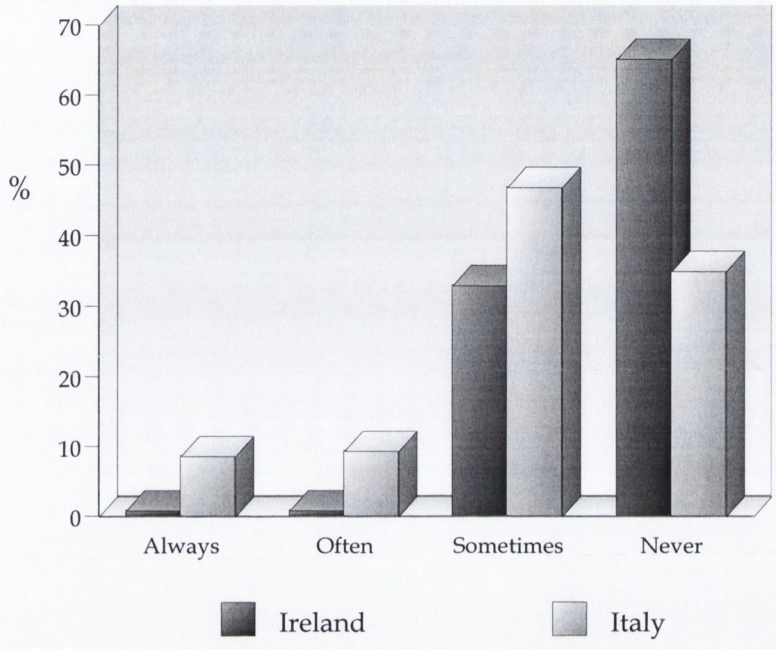
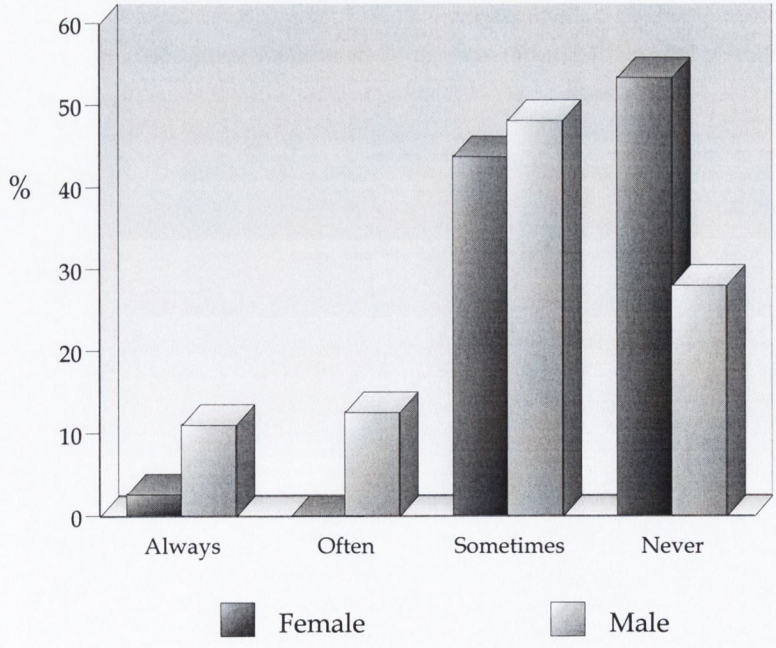


Figure 6.4 Frequency of Attendance at Union Meetings in Italy by Gender



[202] Male Staff Nurse (46 years of age) in *Azienda*, Interview 2-14.

Naturally, attendance at union meetings is not the only form of participation, and informal contacts between members and representatives may also be important. These contacts take place within individual wards or in centralised changing-rooms, for example, or function via friendship networks. As I will show in the next section, these kinds of contacts played a key role in the process of union renewal that took place in *Presidio* in early 1998. An Irish union representative describes how informal contacts can encourage formal participation:

> *[Researcher: How did that meeting go, what was the attendance like?] From here? Very good, it was excellent from here, so there is room and there was another meeting a few days ago. Xxx came in on Tuesday, now I was working but I organised the whole thing. I went round and put out leaflets in all the wards, went round on Tuesday morning after work, and on Monday night and went round all the wards to tell everybody. Because even when you put up a notice they'll say the next day "oh if I'd known I'd have gone" or "I forgot that was on" or "I'd like to have gone" and you could turn up and there might be nobody there.*[203]

One of the main obstacles to participation in union activities is the nature of nursing work and the difficulties that this creates for nurses in attending union meetings:

> *Everybody here in the hospital must be a member of the INO, there would be a big majority here would be INO members. But they are very bad even at getting involved in their union. They tend to leave it to everyone else and they also tend to accept a lot of changes that are brought in without questioning them. But that's, it's slowly but surely changing. [Researcher: First of all, why do you think that people are so accepting?] Maybe because it's very, very busy for a start.*[204]

In Italy, the lack of membership participation was highlighted by nearly all of the interviewees and was attributed primarily to their lack of trust in the existing representatives and the unwillingness of the latter to keep members informed and to call meetings and assemblies:

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[203] Female Staff Nurse (34 years of age) and INO representative in *Voluntary Hospital*, Interview 1-10.
[204] Female Ward Sister (35 years of age) and INO representative in *Voluntary Hospital*, Interview 1-8.

> *It seems as if the unions are getting more active now, because they have lost a lot of ground, but the result is that if a meeting of all staff members is called – an assembly – these assemblies are practically empty… And that's damaging, because then you play into the hands of the other side, of management.*[205]

As I noted earlier in relation to Figure 6.3, there are considerable gender differences in the participation rates of male and female nurses in Italy. The gender composition of the nursing workforce in Anglo-Saxon countries is often considered a key factor in explaining the weakness of local union structures in nursing (Bellaby & Oribabor, 1980: 163; Carpenter, 1980: 142-3; Hart, 1994: 125-127). For example, Hart (1994) provides the following summary of factors that discourage participation amongst female nurses:

> *As well as economic stressors and possible resentment from within the family – husbands especially – the demands of a stressful job and running the home are well documented obstacles to prevent women then committing themselves to a 'third career' as a trade union representative. Even for younger women without home responsibilities there are factors that hinder involvement and progress in the movement. Male domination in the unions has, in the past, been frequently associated with sexism or, at the least, a strongly male and hierarchical culture where the bureaucratic rules and methods of operating have traditionally made it difficult for women to participate.* (Hart, 1994: 127)

In this context, it is interesting to look at how male and female union members in Italy think about their unions and how they relate to their representatives. In fact, female union members in Italy typically attribute their low levels of participation in union activities to a lack of faith in the existing representatives, rather than emphasising their gender. Nevertheless, they also stress the obstacles that family responsibilities pose in relation to union involvement – pointing out that they simply do not have the time to become a representative or to get directly involved. Thus, the obstacles to becoming a union representative tend to inhibit participation *per se*, given the poor functioning of the unions in the Neapolitan hospitals:

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[205] Male Staff Nurse (48 years of age) in *Azienda*, Interview 2-16.

You would have to go there basically (i.e. to the regional headquarters of the union), and organise things with them, leap-frogging the local union. But what would you achieve – you would end up putting yourself against these four (representatives). Second Interviewee: But we have even done this. … The only problem is that then they say "one of you who works in the hospital, and who therefore lives the problems, should get involved". But we are all married women! [Researcher: It would require a lot of energy?] It's not the energy, you need time. As it is, we have no time for ourselves, for our hobbies, to read a book or just put our feet up – if you have no time for that, how can you take on union duties?[206]

In this context, one might inquire whether younger women are more actively involved in union activities, as this group may have greater availability and fewer family responsibilities. However, none of the young female nurses in Italy (i.e. those under 30 years of age) participate in union meetings and 46% of female nurses between 30 and 39 years of age participate occasionally. Although the latter percentage is slightly higher than the corresponding figure for older women, it does not suggest that younger nurses 'compensate' for the lower participation rates observed amongst their older colleagues. The most plausible explanation for this is that the only contact that younger nurses have had with workplace unionism has been with relatively dysfunctional structures. This has tended to lead to their *complete* withdrawal from the unions, rather than encouraging participation. This is compounded by the lack of female role-models within the unions. In fact, in the three case study hospitals in Italy, there were only three high-profile female workplace representatives from the CGIL, CISAL and CISL unions (although a number of other women held elected positions as representatives without playing a very active role).

The CISL representative is actively involved in promoting the participation of women in her union, as the following extract indicates:

[Researcher: In your experience, do female health workers have a different relationship with their union?] Let's say that for the women who work in the health service there is the question of shift work, and this is particularly true for nurses,

[206] Two female Midwives (31 and 45 years of age) in *Presidio*, Interview 3-5, 3-6.

which means that there is not always a great availability, you could say. ... It's difficult to find women who are willing to get involved, or at least to make themselves available. ... In the Coordinating Group (for women in the CISL), we have put forward a cultural argument, in the sense that a union organisation cannot hold meetings at seven o'clock in the evening or six o'clock – late – because obviously that leads to a self-exclusion, because you make your choice and you say hang on, maybe your family responsibilities are more important, even though the other things are important as well. So what idea did we come up with? A new approach, in which union meetings no longer happen in the evening, but rather at a more appropriate time.[207]

In conclusion, it is important to point out that whereas family responsibilities may reduce the willingness of women to become union representatives, these do not necessarily preclude participation in the activities of local union branches. The main obstacles are linked with the nature of the existing union structures rather than an unwillingness to get involved or to participate. In this sense, it is significant that 47 per cent of female Italian survey respondents participate in union meetings at least occasionally. Although the corresponding figure for men is 72 per cent, the female participation rate is nevertheless considerably higher than the Irish rate of just 33 per cent.

Union Renewal

The importance of theorising the different tendencies inherent in union representation is underlined by the process of 'union renewal' (Fosh, 1993). Union renewal occurs when union members attempt to transform existing union structures in order to create a more effective form of organisation. Fairbrother (1994a, 1994b, 1996) links union renewal with the rationalisation of the public services in Britain during the 1980s and 1990s. As the devolution of management authority created space for local bargaining, in a number of workplaces a new layer of union representatives became active: "local or workplace union groups may begin to consider the way they organise as collective bodies, so as to

[207] Female hospital representative for the CISL union in *Azienda*, Interview U-1.

articulate the immediate concerns of their membership" (Fairbrother, 1994a: 166). Dundon (1998) provides a similar perspective on the potential for union reform within the 'reformed' public sector:

> *...devolved management systems, pressures from increasing market competition, employment reorganisation and work intensification have been traced to a resurgence of union activism. As management become increasingly self-confident, demanding greater employee flexibility, there is evidence of a revitalised union response in defence of members' terms and conditions.* (Dundon, 1998)

However, union renewal remains just one of the possible outcomes of rationalisation, as inexperienced and poorly-organised local union branches may be swept aside or co-opted by management, or a top-down process of union renewal 'by fiat or decree' may prevail. Colling (1995) also raises the possibility that union renewal in the context of managerialism and privatisation may merely lead to fragmentation and parochialism if responses are not coordinated at national level (cf. Foster & Scott, 1998).

Union Renewal: Empirical Findings

In this section I will concentrate on 'bottom-up' processes of union renewal in the case study hospitals. The evidence from fieldwork in Naples and in Dublin is rather mixed in relation to this issue: although health service rationalisation seems to have created the conditions for renewal in all of the case study hospitals by generating anger over work grievances, this was linked directly with managerialism in only one of the hospitals, *Azienda*. The cavalier approach of the new manager appointed in 1996 (see Chapter Four) triggered a process of union renewal that resembles, at least to a certain extent, the model described by Fairbrother, Fosh and others. By refusing to allow union representatives to influence managerial decision-making, the *Direttore Generale* threw the unions into a state of crisis. Nevertheless, once they realised that they could no longer count on managerial support in order to sustain membership levels, union representatives sought to mobilise their members in order to obtain recognition.

The removal of the previous union leaders in this hospital in the early 1990s – many of whom were charged with involvement in bribe-taking – meant that a new layer of activists came to the fore. As management was no longer willing to concede favours, and because all union representatives were now forced to work, it was easier for union representatives to present a 'new image':

> *We no longer want to do favours for people – nor can we do this any longer, because this type of management is very rigid and severe// [Researcher: It just isn't on?] No way! This has (pause) favoured a development that we already wanted to bring about, namely to do away with this type of union representation. Today, if somebody asks me for something that he or she is not entitled to, I say no. However, before I used to say yes, because the subscription was more important than the principle. Today we give much more importance to union principles than to subscriptions.*[208]

Although this was 'too little, too late' for many nurses, it nevertheless created a new atmosphere in the hospital. A number of localised initiatives were taken which brought the unions together – a considerable achievement, given that there are more than twenty unions in the hospital. However, this proved short-lived, again due to the abilities of the General Manager:

> *In fact it was a proposal of ours, of the UIL, that brought all the different union organisations together, and we remained united during negotiations with management for almost three months, even to the point of getting together before meetings and then going in to negotiate with management. This is a fairly impressive achievement. … But management is cunning, and tries to divide us:* Divida et impera. *… In fact, it was a decision by the* Direttore Generale, *who intervened directly to promote a representative from one of the autonomous unions, that brought about the split.*[209]

[208] Male Staff Nurse (42 years of age) and UIL representative in *Azienda*, Interview 2-21.
[209] Male Staff Nurse (42 years of age) and UIL representative in *Azienda*, Interview 2-21.

Nurses in *Presidio* – where there was no increase in managerial autonomy and local bargaining was non-existent – undertook a more decisive bottom-up initiative to renew local union representation during the period of fieldwork. The initiative began in the men's changing-room, as nurses gradually realised that many of their individual problems arose from common grievances. Therefore, by exchanging experiences and 'grumbling' about working conditions in this moment of socialisation at the end of their shifts, nurses themselves created the initial momentum for renewal:

> *It began… Do you know the changing-room where we get undressed? At the end of the day there are always people giving out about this and that, for whatever reason, and the thing basically began with the young lads, and we decided: "let's get together". And the older nurses, who generally have experience in these matters – and for that reason we listened to them – said that just 'to get together' would lead nowhere. We had to use a union in order to be heard. Us youngsters accepted this advice and we started to get organised. On my shift we did this thing, we recruited fifty people to the union.*[210]

The issue that triggered this protest was the poor quality of the uniforms provided to nursing staff after a delay of almost seven years. Although this was ostensibly the cause of the revolt, union renewal was also driven by anger at the impossibility of taking statutory leave from work due to staff shortages. Thus, union renewal in *Presidio* was directly related to unresolved grievances of a specific nature. Indeed, it is impossible to understand the dynamics of this process without having an understanding of the origins and character of these grievances. Because the existing union representatives failed to tackle these problems, the initial aim of the renewal initiative was to replace these individuals. Alongside the poor performance of the representatives, activists identified falling membership levels and a lack of participation as the principal factors underlying the weakness of the union. They therefore undertook a recruitment campaign and encouraged other nurses to participate in the union.

This initiative forced CGIL officials at branch level to intervene, placing the local branch under central control pending elections. A series of highly-conflictual meetings

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[210] Male Staff Nurse (34 years of age) in *Presidio*, Interview 3-9.

were held in which union members voiced their criticism of the existing representatives and their ideas about how the union should function. The candidate proposed by the 'reformers' was elected in subsequent elections, and membership levels in the CGIL more than doubled within the space of a few months.

This initiative illustrates a number of features of nurses' aspirations in relation to the 'representative relationship': a basic 'collectivism', the importance of appointing new representatives from within the nursing category on the basis of personal relationships and the need for democratic procedures within the union. It illustrates the possibility of renewing union structures by means of collective action within the workplace.

However, there were also a number of weaknesses inherent in the initiative. Firstly, there was an explicit 'gender' dimension to the process of union renewal in *Presidio*, from its very inception in the men's changing-room. Activists appeared oblivious to the need to actively encourage their female colleagues to get involved and to develop organisational forms conducive to this. Secondly, there was a tacit assumption that the initiative would be based within the nursing category, and activists seem to have rejected the idea of approaching auxiliaries and cleaning staff for support.

Union activists also placed undue emphasis on the attributes of the new representatives, as if the only issue of importance was the election of a different group of people. This led them to underestimate the difficulties involved in transforming the structure of representation, on the one hand, and resolving the main work grievances, on the other. Nurses initially intended to hold assemblies every 15 or 30 days in order to monitor progress, and there was talk of setting up a network of union representatives within the wards. However, these aspirations were never realised, primarily due to the organisational burden involved and the obstacles to participation by union members themselves.

The hope that a more effective union representative would be able to resolve outstanding work grievances proved to be misfounded. Hospital managers and health service administrators simply did not respond to the unions' demands, and members grew increasingly demoralised. Staffing levels continued to drop and the representative

elected as a result of the union renewal initiative became less active as time went by. After the initial surge of enthusiasm, full-time union officials from the CGIL branch at the level of the Local Health Unit called a second meeting, where they informed union activists that they could not simply do what they liked at local level, that it was important to coordinate the actions of nurses in different hospitals and that they were already dealing with the key issues at a higher level.

In addition to the election of new representatives, the experience of union renewal at *Presidio* suggests that in order for union renewal to be effective, the *organisational form* of workplace unionism must be transformed. Moreover, if initiatives at local level are not combined with more general strategies of mobilisation, individual activists are likely to remain isolated and to become disillusioned.

Turning now to *Emergency Block*, where the frustration of nurses is as severe as in the other Italian hospitals and where local bargaining has already begun, no signs of grassroots union renewal are apparent:

> *There should be a law to say that members should be kept informed, holding meetings every now and again – but it never happens. … They hold elections as if they were selling indulgences, with one candidate or at most two.*[211]

> *Just think, the union representatives here refuse to call assemblies with the workers because they are afraid of being attacked, of being kicked out! There hasn't been an assembly in years.*[212]

Finally, a limited process of bottom-up union renewal has taken place in *Voluntary Hospital* – the Irish case study hospital – primarily as a result of the nurses' pay campaign in 1996-97. Although this has not had a major impact on participation levels or on the structure of workplace organisation, there is evidence that existing representatives have become more assertive and that a couple of new people have become involved:

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[211] Male Staff Nurse (44 years of age) in *Emergency Block*, Interview 4-1.
[212] Male Staff Nurse (46 years of age) in *Emergency Block*, Interview 4-3.

But she's an EXCELLENT union rep. I'm not sure how long she is the rep because she wasn't before I went away, but everybody knows her. [Researcher: Really, everybody knows her in the hospital?] Yeah. Like even yesterday she was up – there will be another meeting on Tuesday here in the hospital – and she came up, and she made it her business to speak to everybody and she introduces herself.[213]

Although young Staff Nurses participated in the pay campaign, and were arguably at the centre of the wave of militancy that led to the national strike in 1999, these nurses have remained rather wary of getting involved with the union. This appears to be due, at least in part, to the dominance of Ward Sisters and Unit Nursing Officers within the local leadership. Once again, this indicates the importance of studying the 'representative relationship' in the social context of the hospital. In the past, union representation was generally conceived as an 'informational' role confined to the circulation of union notices, and this role was generally absorbed into the tasks of line managers:

[Researcher: You had this role thrust upon you, basically?] That's right. As soon as I got the Junior Ward Sister's post in xxx ward, which is probably in August of '95. With that role obviously, automatically, came this INO rep, just for the ward. [Researcher: What, was that on the basis of tradition?] Yeah, tradition. And because the mail came to the INO rep and it was kind of the Junior Ward Sister's... And nobody else wanted it, you know. Like, industrial relations is not a nice word, it is not a word we use every day. We rarely, if ever discuss it. [Researcher: Particularly back in 1995, it was low profile stuff?] Absolutely, VERY low profile.[214]

Outside the hospital, union organisation is even more fragile, as one representative observes:

Now it sounds fantastic, like there's ten thousand members right … but when we have our meetings (i.e. of the Dublin Branch of the INO) about thirty people turn up and that's a big meeting! That's a big meeting. So like I mean if thirty people

[213] Female Staff Nurse (25 years of age) in *Voluntary Hospital*, Interview 1-5.

turn up, I mean – and they're usually the same thirty people – what about all the people that are here?[215]

On the basis of the fieldwork carried out in Dublin and Naples, therefore, it is possible to conclude that the main effects of health service rationalisation on local union organisation are mediated by their impact on work grievances. To the extent that a bottom-up process of union renewal has occurred in the case study hospitals, it has been primarily driven by anger over staff shortages and the lack of resources. Far from being automatic, local union responses to rationalisation appear to depend on initiatives taken by individual nurses or by small groups of nurses. For example, in *Presidio*, a group of three or four nurses took the initiative of visiting other wards during the night shift, explaining that they intended to change the way the union functioned at hospital level and signing people up to the union. In *Voluntary Hospital*, two relatively assertive union representatives achieved a reputation within the hospital in the space of a few months by adopting a more 'hard-headed' approach to addressing local grievances.

Nevertheless, in *Azienda*, a more systematic form of union renewal was observed and this may be linked with the strategies adopted by the General Manager, who was determined to implement the main elements of the health reforms passed in 1992-3. However, the replacement of the management team in 2001 has interrupted the process of renewal and seems to have favoured a return to a more clientelistic form of representation.

Work Grievances and the Representative Relationship

It is clear, therefore, that work grievances play an important role in shaping the structure and content of workplace union representation. In this section I will present the results of a statistical analysis of survey data collected in the case study hospitals, with the aim of providing a slightly different perspective on this issue. I will begin by assessing whether union members differ from non-members in their evaluation of the seriousness of a range of grievances. In Chapter Five, I presented the results of a factor analysis of

[214] Female Unit Nursing Officer (35 years of age) in *Voluntary Hospital*, Interview 1-7.

nurses' responses to a series of questionnaire items dealing with grievances. Three clusters of grievances were identified, relating to *retirement*, *working conditions* and *professional advancement*. Table 6.9 below reports the mean factor scores for union members and non-members in Ireland and Italy on these three dimensions. The values that appear in the table represent differences from the grand mean for the pooled data in standard deviation units.

Table 6.9 Composite Indices of Work Grievances by Union Membership

	Ireland		Italy	
Scale	Member	Non-member	Member	Non-member
Retirement	*-0.16*	*-0.54*	*0.16*	*0.21*
Working Conditions	*-0.14*	*-0.31*	*0.02*	*0.19*
Professional Advancement	*-0.19*	*-0.47*	*0.20*	*0.21*
Sample Size	*226*	*31*	*263*	*228*

Table 6.9 confirms the existence of considerable differences in the level of concern about *retirement* and *professional advancement* between Irish and Italian nurses, the latter expressing a higher level of dissatisfaction with their work situation. There are also significant differences between union members and non-members in Ireland in relation to all three clusters of grievances, non-members expressing much less concern about *retirement*, *working conditions* and *professional advancement* than those who are in a union. This is consistent with the hypothesis that work grievances encourage Irish nurses to join a union. Interestingly, however, non-members in Naples are much more aggrieved about *working conditions* and a little more concerned about *retirement* issues, although there are practically no differences in relation to *professional advancement*. This is arguably the consequence of union clientelism and the degeneration of workplace unionism in the Italian hospitals. In particular, nurses who have strong feelings about understaffing, workloads, quality of care, pay, shift organisation and working hours are *less* likely to be in a union.

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[215] Female Staff Nurse (34 years of age) and INO representative in *Voluntary Hospital*, Interview 1-10.

I have highlighted the fragmentation of union representation in Italy on a number of occasions, and the question therefore arises whether nurses who feel more strongly about *professional advancement*, for example, or *working conditions*, are more likely to join specific kinds of unions. Table 6.10 below summarises the survey evidence in relation to this issue by providing mean scores for each of the main types of union found in the Italian case study hospitals. The values reported in the table refer to a factor analysis *of the Italian data only*, and the reference point is therefore the mean for the *Italian nurses* in the sample.

Table 6.10 Composite Indices of Work Grievances by Union Type

Union Type	*Retirement*	*Working Conditions*	*Professional Advancement*	*Sample Size*
CGIL	*0.10*	*0.12*	*0.11*	*75*
CISL	*0.14*	*0.13*	*0.25*	*32*
UIL	*-0.33*	*-0.40*	*-0.15*	*46*
Traditional Autonomous Union	*-0.13*	*-0.15*	*-0.03*	*51*
Rank & File Union	*0.37*	*0.07*	*-0.02*	*12*
Professional/ Category-based Union	*-0.01*	*-0.16*	*-0.13*	*43*

Table 6.10 reveals considerable differences in the subjective grievances of nurses who belong to different kinds of unions in Italy. As far as *retirement* is concerned (i.e. retirement age and pension levels), members of the UIL union express the lowest level of concern (-0.33), whereas members of the rank-and-file unions have high scores on this scale (+0.37). However, with just 12 respondents in rank-and-file unions it would be dangerous to draw firm conclusions from this finding.

Turning now to *working conditions* (i.e. understaffing, workloads, shift organisation, hours worked, quality of care and pay), UIL members once more have much lower scores than other nurses (-0.40). The highest level of concern about *working conditions* is expressed by CISL members (+0.13), followed by members of the CGIL (+0.12). It is

interesting to note that nurses in professional or category-based unions (principally FAPAS) express a lower degree of concern about this set of issues. Finally, in relation to *professional advancement* (i.e. promotion opportunities, access to training and work autonomy), CISL members have the strongest grievances (+0.25), followed by members of the CGIL (+0.11). Thus, there is no evidence that the category-based FAPAS members, for example, are more concerned about issues of professional advancement, although members of rank-and-file unions seem to have stronger feelings in relation to pension levels and retirement age.

It is possible to gain additional insights into the relationship between grievances and union membership by conducting a regression analysis of the survey data. Using the technique of Logistic Regression, which was designed for use with dichotomous dependent variables, I will regress an indicator of union membership on measures of grievances (*retirement*, *working conditions* and *professional advancement*), work orientations ('militancy' and 'vocationalism') and a range of control variables[216]. Because of the differences noted earlier in the relationship between grievances and union membership in Ireland and Italy, I will include a multiplicative interaction term between country and the three measures of grievances. Variables that are not statistically significant at the 0.05 level are excluded sequentially in order to obtain a parsimonious and robust model. The Hosmer-Lemeshow chi-square statistic for the final model is 4.7 (8 degrees of freedom), which is associated with a highly-satisfactory significance level of 0.79. Furthermore, the model correctly classifies 88 per cent of union members using the pooled data (the overall sample size is 792). Table 6.10 below summarises the results of the model, including the logit coefficient, standard error, significance level and odds ratio for each variable included in the estimation.

[216] The control variables are country, age, gender, marital status, having children, employment grade, employment status, ward type, experience of nursing and average working hours (see Chapter Five for variable definitions).

Table 6.11 Results of Logistic Regression Model on Union Membership

Variable	Logit Coefficient	Standard Error	Significance Level	Odds Ratio
Country	*2.54*	*0.28*	*0.000*	*12.67*
Employment Status	*-2.29*	*0.76*	*0.003*	*0.10*
Marital Status	*0.46*	*0.21*	*0.027*	*1.58*
Age	*0.03*	*0.01*	*0.002*	*1.03*
Working Conditions	*-0.17*	*0.11*	*0.11*	*0.84*
Wkg Conditions by Country Interaction	*0.57*	*0.23*	*0.01*	*1.76*

The results of the Logistic Regression model must be interpreted carefully due to the inclusion of an interaction term. The odds of union membership for Italian nurses with low scores on *working conditions* (i.e. one standard deviation below the mean) are roughly 20 per cent above those for Italian nurses with average scores on this variable. Conversely, the odds of union membership for Italian nurses with high scores on *working conditions* (i.e. one standard deviation above the mean) are roughly 15 per cent lower than those for Italian nurses with average scores. As far as the Irish nurses are concerned, the odds of union membership for nurses with low grievances on working conditions are 8.5 times greater than those for Italian nurses with average grievances (the reference category). The odds of being in a union for Irish nurses with average grievances are 12.7 times those of their Italian counterparts. Finally, the odds of union membership for Irish nurses with strong grievances in relation to *working conditions* are no less than 19 times greater than those of Italian nurses with average grievances. Thus, in the Irish context, grievances in relation to staffing levels, workloads, shift organisation, hours of work and quality of care appear to have a major impact on the decision to join a union.

The modelling results also suggest that married individuals and those with a permanent contract are more likely to be in a union, and that the likelihood of joining increases with age. The odds of union membership for temporary nurses are roughly one-tenth those for permanent employees, and married nurses are almost 60 per cent more likely

to join a union than those who are single, divorced or widowed. A ten-year age gap is associated with a 30 per cent increase in the odds of union membership, controlling for all other variables in the model. The most interesting finding of this model is that once we control for age, marital status, occupational status, country and *working conditions*, the other variables do not have a statistically significant effect, including gender, grievances, orientations, children and employment grade.

I will now turn to the question of organisational forms and evaluate how top-down processes of union restructuring have interacted with union renewal at workplace level.

Organisational Forms

The most important change in the organisational form of workplace unionism in the Irish hospitals is undoubtedly the decision taken by the INO at its 1998 conference to transform its branch structure. The aim of the union leadership is to upgrade the autonomy and capacities of local representatives in order to 'keep their finger on the pulse'. Liam Doran, then Deputy General Secretary of the INO provided the following account of this process:

> *We have a situation where our present structure has not changed materially from when the membership was 10 or 12 thousand. Now it is double that. Like the Dublin branch has nearly 10 thousand people in it! ... So we have to bring the branch structure, bring the core unit of the union which is the branch structure much closer to the level of major employment centres... [Researcher: The idea is that in the big hospitals there would be a branch in the workplace?] And a hospital secretary in that branch, and he or she will do the business. [Researcher: What would be the difference between that and the Reps which are currently in the hospitals?] Well, number one, we will have more of them. Number two we will have more training to give them. And we are contemplating targeting a rather craft worker-type situation where we will... if somebody wants to go job sharing, wants*

to give up nursing, they can do that kind of job half-time for us and we will pay them. And they will be based in the hospital.[217]

Interestingly, the INO's strategy for the reform of workplace union structures involves a top-down process that takes as its point of departure the impossibility of creating a sustainable structure of workplace unionism on a voluntary basis. There is now explicit recognition of the need to rely on a *representative*, rather than a *participatory* structure of workplace unionism. The main role of this structure will be to develop a 'strong bargaining relationship with management':

Our representatives are generally not yet ready to go face to face with management and say "listen, those changing facilities in ward Y are not acceptable, change them". And don't blink. We still haven't got to that level. [Researcher: What do you think it takes, do you think that will come from stronger//] //More training, I think it is not... I think we are going to have to be more focused in the number of Reps we have. [Researcher: So you actually want this network of representatives to function as shop stewards would do in industry?] Oh Yeah, absolutely. BUT I think for the foreseeable future, if I'm honest Jon, we will not reach that level with 800 Reps. We will reach that with some of them. And the only other way that we can ensure that the INO does its business at the level of the workplace, for the average member is by employing more full-time officials.[218]

Although the reform of the INO branch network involves the creation of a layer of union representatives who are closely integrated into the official structure of the union – with a consequent risk of routinisation and bureaucratisation – it may nevertheless resolve some of the weaknesses in union representation at hospital level. As I noted earlier, many nurses are reluctant to get directly involved with their union and are wary of approaching union representatives who are Ward Sisters or Nurse Managers. Thus, the independence of the full-time union officials from the occupational hierarchy of nursing may enable them to overcome the deference that traditionally characterised local INO representatives. The existence of several combative Industrial Relations

[217] Liam Doran, Interview U-11.
[218] Liam Doran, Interview U-11.

Officers at regional level already seems to have given union members greater confidence in addressing their grievances at local level. One of these officials provided the following account of her relationship with Nursing Management in one of the hospitals that she is involved with:

> *A couple of weeks ago I was negotiating in xxx hospital, on a practice that was unprofessional and pure dangerous that nurses in Theatre were involved in, and I advised them to stop yesterday, and their attitude was that 'we better give a bit of lead-in, in deference to the management'. ... At the beginning of the day you would have a series of 10 syringes of one type and 10 syringes of another type for whomever comes into the Theatre. And we wrote to them and the Personnel Officer got on to me in a very treacly manner: "withdraw it and we will talk about it". I said there was no withdrawing, this is going to stop on Friday, this is how it is, it is illegal, you as a nurse know it's illegal. And that is the only threat that you technically have to put before managers. The nurses are totally and absolutely sidelined. And we got an absolutely scathing letter back from them basically deploring our industrial relations technique, blah blah blah. And nurses, by virtue of being nurses, should do what the Consultant wanted.*[219]

As I mentioned in Chapter Three, the 1993 Accord in Italy contained a number of provisions relating to workplace union organisation, and over the course of the following three years a fundamental restructuring of local union structures was implemented. The outlines of this reform were established in 1991, when the CGIL, CISL and UIL reached agreement on the creation of *Rappresentanze sindacali unitarie* (RSU). The RSU are similar to works councils, as they are elected by all workers and have the right to conduct local negotiations within the limits established by the 1993 Accord and by national contractual agreements. They differ from shop stewards' committees by virtue of their institutional form, broad representative function, their right to be informed and consulted about specific issues and by their participation with management in specific areas of decision-making. Elections are held every three years, and candidates must be members of 'formal union organisations'; informal 'lists' and individuals are therefore excluded from participation (Carrieri et al., 1997).

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[219] Female Industrial Relations Officer from the INO.

As a result of the 1993 Accord between the CGIL, CISL and UIL unions and employers' representatives, one third of seats on the RSU are reserved for the signatories of the interconfederal accord and relevant national contracts. Other unions must indicate their acceptance of the regulations imposed by the Accord as well as collecting signatures from at least 5 per cent of those eligible to vote. The aim of these regulations is clearly to exclude 'disruptive' elements and to ensure that CGIL, CISL and UIL are able to dominate within the RSU[220].

It is interesting to examine the differences between the RSU and the *Consigli di fabbrica* which emerged during the 'hot autumn'. As I mentioned in Chapter Three, the *Consigli* were characterised by an attempt to 'mirror' the structure of the labour process by electing a *delegato* within each section of the factory and by their 'unitary' composition (any worker could stand for election, all workers could vote and a blank ballot paper was used). Moreover, the *delegati* were instantly recallable by their electors and, while the level of industrial struggle remained high, democratic participation in union assemblies and the use of binding mandates ensured a close alignment between the demands of union members and the negotiating platform adopted by their representatives. Therefore, the *Consigli* embodied a desire to link the 'representative relationship' with a personal relationship of trust and accountability between fellow workers within a specific area of the workplace.

In contrast, the RSU embody a form of representative democracy in which workers have little control over their representatives in the period between elections. Although the RSU has the right to hold assemblies, there is no obligation to submit local agreements to a binding referendum. The gulf between workers and their representatives is heightened by the abandonment of section representatives: all RSU representatives are elected at the level of the workplace as a whole. In large workplaces, this results in a more distant and 'formal' relationship between workers and their representatives, particularly as one third of RSU representatives are appointed rather than being elected.

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[220] Participation in national negotiations is circumscribed by a number of other regulations relating to membership levels and geographical coverage.

The RSU embody a 'representative' rather than a 'participatory' form of union democracy and the legislative guidelines arguably encourage the 'juridification' of workplace representation. The 1993 Accord imposes rigid constraints on local bargaining and stipulates a legal right to be informed and consulted about certain aspects of managerial decision-making and to participate in a precisely-delimited local bargaining sphere. These measures are likely to encourage the "professionalisation of workplace representation" (cf. Hyman, 1989: 155), particularly in large workplaces where RSU members will be able to claim extensive time off. As Boraston et al. (1975) observe: "...in co-operation with employers, unions can limit the business left for decision in the plant by means of a collective agreement at a higher level... Such agreements do not destroy the independence of the workplace organisation, but they limit the scope for its application and thus transfer authority to higher levels of union organisation" (pp. 195-6). Gaetano Marati, leader of the rank-and-file RdB union in Naples, reinforces this point:

> *There was a risk of turning into 'union officials', union bureaucrats, getting caught up with negotiations – because you can't negotiate anything at the end of the day, it's a fake, they decide everything. And in fact that is what happened. Only the most politicised comrades managed to maintain an oppositional union stance. The others cannot even make it to local union meetings any more, because they have 'the commission' (ironic tone), or the 'negotiations on article 1 or on article 2'. This has been a real trap for us.*[221]

In this sense, there is a strong link between the organisational structure of the RSU and the nature of concertative bargaining in Italy. Just as neo-corporatist arrangements at national level provide union leaders with a degree of influence over the formulation and implementation of public policy, in exchange for wage restraint, the RSU seek to create a form of 'partnership' at local level: workplace wage bargaining must be based on productivity growth at local level and union representatives have a statutory right to be informed about certain management decisions, to express an opinion on others and to be consulted on a third set of issues. The confederal unions – CGIL, CISL and UIL – view this model as offering the possibility of 'revitalising' workplace union structures,

[221] Gaetano Marati, Interview U-6.

extending the influence of the unions, increasing the level of democratic involvement in union decision-making and therefore responding to the challenge of the 'new union actors'.

The outlook of CGIL representatives, in particular, conforms to the general model of 'strong bargaining relations' described by Batstone (Batstone, 1988; Batstone et al., 1977; 1978). Batstone emphasises the need for 'leader' stewards who can shape a strategic plant-wide perspective supportive of unity and collectivism, cultivating pragmatic and informal contacts with management and establishing 'strong bargaining relations' based on compromise and mutual gain. Batstone shows that the Report of the Donovan Commission in Britain in the late 1960s was fully consistent with this model. The report recommended that union rules recognise the mode of election, tenure of office and role of the shop steward, that they should not hinder the development of inter-union steward committees that formulate union policies at plant level and that employers should be willing to provide time off from work and facilities for stewards in order to assist these developments (Batstone, 1988: 72-73). There is therefore a notable similarity between the RSU reforms in Italy and the reforms that followed from the Donovan Report in Britain. A workplace representative in *Azienda* provided the following summary of the relationship that he aims to establish with hospital management following the RSU reforms:

> *After a year, year and a half of giving him* carte blanche, *he [i.e. the General Manager] has done some positive and some negative things. We have now decided that enough is enough, and from now on everything has to be done in the following way: where we are entitled to be heard, we want to be heard, where we have to be informed, we want to be informed, and where we have a right to negotiate, we want to negotiate, without getting the three things mixed up, because our contract foresees 'information, bargaining and consultation'.*[222]

In a certain sense, therefore the aim of CGIL, CISL and UIL seems to be to use the RSU as a means of participating in the implementation of the health service reforms, in order to ensure that hospital managers respect the terms of national agreements and follow the

[222] Male Staff Nurse (42 years of age) and UIL representative in *Azienda*, Interview 2-21.

legislative framework laid down in 1992-3. By creating an elected workplace structure that permits a stronger coordination and regulation of local representation and bargaining, the confederations also hope to stimulate participation and to marginalise the rank-and-file unions. Given the vagueness surrounding the rules regarding the election of workplace representatives and the degeneration of local union structures, the new reforms represent a considerable step forward, notwithstanding the shortcomings of the RSU in relation to democratic participation and accountability.

It is possible to link the reform of the INO's branch network and the RSU reform in Italy with recent debates about union models and the 'organising union'. Carter & Fairbrother (1998) suggest that, "[f]aced with traditions of bureaucratic and undemocratic business unionism, unable to represent labour effectively in changed conditions, there has been in America, from the late 1980s, a growth of influence of the organising model of trade unionism" (1998: 1). For example, following the AFL-CIO in the US and ACTU in Australia, the British TUC established an Organising Academy which seeks to provide union representatives and officials with a new set of tactics for enhancing the retention of members and for dealing with employers who refuse to recognise the unions. In the US, the hostility of employers has forced unions to intervene in order to create and sustain local representative structures and organisation (Bronfenbrenner, 1997). The AFL-CIO has sought to use new forms of organising, concentrating the power of the union against major employers as well as taking up questions of plant technology and work organisation (Carter & Fairbrother, 1998). The Australian Congress of Trade Unions (ACTU), under the influence of the 'New Voice' candidates in the US, adopted three principles as part of its 'Organising Works' programme: 'like should recruit like'; 'organise or die', and 'members should be empowered' (Carter & Fairbrother, 1998: 11).

In a study supported by the AFL-CIO, Bronfenbrenner (1997) examines the characteristics of successful union recognition campaigns and concludes that "union success in organising depends on running campaigns with a focus on representative leadership, personal contact, dignity and justice, and building an active union presence in the workplace from the very beginning of the campaign" (Bronfenbrenner 1997: 198). Nevertheless, Moody (1997) and Slaughter (1997) point to the weaknesses

inherent in the strategies of the AFL-CIO. They suggest that despite its radical rhetoric, the union has not departed from the model of 'business unionism' and has not developed a means of dealing with the 'tough problems' of lean production, downsizing and subcontracting. Carter & Fairbrother (1998) point to the contradictions inherent in American, Australian and above all British forms of top-down 'organising': "In the more radical form of organising, a much more active form of membership involvement at workplace level will not be content with a partnership with employers, with stable lines of compromise and agreement, but instead will attempt to shift the 'frontiers of control' (Goodrich 1975). Even in the US where business unionism has a longer and more firmly established tradition, the AFL-CIO has begun to develop the realisation of the need to have more control over the work process and not to cede control for a wages bargain…" (Carter & Fairbrother, 1998: 14).

Neither the RSU reform in Italy, nor the reform of the INO branch network have been associated with the rhetoric of the 'organising union', although there are certain similarities between these processes. All three may be linked with the need for unions that are facing new challenges at local level to introduce innovations in their local structures. Moreover, *all* of these processes take place within the context of the existing national structures, policies and strategies of the union actors concerned. This inevitably conditions the nature of the workplace reforms that are implemented. As far as the Italian unions are concerned, the primary importance attached to the maintenance of a tripartite structure of concertative bargaining means that local union organisation cannot simply be encouraged to adopt a more 'aggressive' stance in relation to wages, conditions or the implementation of the health service reforms. Although the INO has a relatively weaker attachment to national 'Partnership' agreements, it effectively curtailed strike action in 1999 and focused attention on national negotiations rather than encouraging militancy. Thus, the evidence from the current research confirms that top-down processes of 'union organising' are inherently contradictory, as they tend to impose limits on the autonomy of local union structures whilst simultaneously encouraging participation and involvement.

Arguably, the rank-and-file unions in Italy seek to combine distinctive 'top-down' and 'bottom-up' forms of union renewal, with a view to stimulating membership participation and encouraging militancy. The growth of these unions has also had the effect of politicising the question of organisational forms:

> *There was this opening towards the* Consigli *(after the 'Hot Autumn'), as a strategic attempt by the union to regain control over dissent within the movement and to recover from the defeat that it had suffered. And it regained control. However, it then started to change the rules from within. ... This process was accompanied by moves towards concertation, which was its strongest expression. ... We became convinced that there was no longer anything worth changing, that it was impossible to achieve anything from within the union, and that it was necessary to work towards an alternative type of union, one which was different, based upon the principles of the* Consigli. *... The basic principles were that 'everybody votes, anybody can stand for election', that 'the assembly makes the decisions', that 'there are no delegates', 'participation': the foundations upon which we are currently building.*[223]

As Carrieri & Tatarelli (1997) observe, the rank-and-file unions mount an explicit critique of the strategic orientations, organisational forms and 'bureaucratisation' of the confederal unions:

> *At the origins of this separation there is always a disillusionment with the behaviour and choices of the confederal unions, which are accused of lacking internal democracy and being unable to represent workers' interests during negotiations due to their lack of understanding of specific work situations. A polemic in relation to the 'bureaucratisation' of the confederal organisations is another defining element of the rank-and-file unions. They present themselves as the expression of a more immediate relationship with workers and as the vehicle for new and more concrete forms of solidarity.* (Carrieri & Tatarelli, 1997: 31)

[223] Gaetano Marati, Interview U-6.

For example, the Cobas in the school sector adopted an organisational structure in 1987 based on participatory democracy and a minimal formalisation of roles. All leadership positions are elected by the base and based on a binding mandate with the possibility of recall. Day-to-day management is carried out by a coordinating committee whose membership rotates between elected provincial representatives between one assembly and the next (Carrieri & Tatarelli, 1997: 61). This model of rank-and-file union organisation may be traced to the *Comitati unitari di base* (CUB), which emerged during the 'hot autumn'. These rank-and-file committees grouped together political activists and union militants in a combative form of workplace organisation that defined itself in opposition to the 'reformist' unions (see Carrieri & Tatarelli, 1997).

The SLAI-COBAS union also emphasises the importance of maximising democratic participation at all stages of negotiations, enabling workers themselves to exercise control over union initiatives. In the absence of full-time union representatives and functionaries, the assembly assumes a key role in defining the priorities and strategies of the union:

> *...the rank-and-file formations all have this characteristic, that they defer to the assembly at all stages of the collective bargaining process and assign to it the role of vetoing or accepting agreements. The aim is to prevent a bureaucracy from forming, because there are a number of considerations to be made: every organisation needs organisers, but those who do the organising must not become a bureaucracy. That is, they must not take away the workers' right to make fundamental decisions.*[224]

In contrast, the RdB does not exclude the use of full-time union leaders and coordinators. Its institutional structure parallels that of the historic confederations in several respects, with a pyramid of representation from the workplace to the national level. Strategic decision-making is delegated to national leaders and delegates to national conference, which is held every four years. Nevertheless, the RdB retains its oppositional character and encourages membership participation in militant forms of struggle within the public sector.

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[224] SLAI-COBAS union representative in *Azienda*, Interview U-14.

Thus, the analysis of organisational forms in the Italian context is more complex than in Ireland, as a number of related processes are occurring simultaneously within the confederations, the traditional autonomous unions, the professional unions and the rank-and-file unions. All of these unions are now concentrating their attention on gaining influence within the workplace RSU structures, but they approach this task from fundamentally different perspectives. Whereas the confederal unions pursue a model of 'strong bargaining relations' with management, based on a 'responsible' form of representation that is essentially subordinate to the priorities of the national leadership, the other unions view the RSU as a means of extending their influence and promoting alternative policies.

In particular, it is apparent that the rank-and-file unions are seeking to transfer specific models of union organisation from one context (large metalworking plants during the 'hot autumn') to another (public hospitals). These models have been kept alive by union activists with direct experience of this period of struggle, and they strike a chord with public sector workers who came into contact with radical political ideas during the 1970s. The two models that inform the approach of these unions are the informal rank-and-file committees (CUB) created by the extra-parliamentary left, and the relatively more structured *Consigli di fabbrica* that brought together sectional delegates in order to pursue militant action at workplace level. In the rather different context of the public services, these models obviously acquire novel features; for example, the ideological commitment of the leaders of the rank-and-file unions to comprehensive, 'working-class' union representation based on the most exploited workers clashes with their *de facto* concentration amongst relatively skilled groups. Gaetano Marati from the RdB describes this contradiction:

> *...we are not interested in doing favours for people, we are only concerned with obtaining justice – but this presents us in a moralistic light, and makes it look like we are against certain practices. As a result, we are appreciated, and we receive greater attention from more educated workers, even though we are more committed to those who are neglected and marginalised – cleaning staff, for example, are nearer to our hearts because they are the most exploited. Paradoxically, however, the cleaner is more attracted to other unions, because he is more interested in small,*

immediate gains – like an extra hour of overtime – whereas we are conducting a battle against the use of overtime per se*, just to give you an example.*[225]

The final issue that I will deal with in relation to organisational forms is the relationship between union organisation within the workplace, on the one hand, and the wider labour movement, on the other. As I noted at the beginning of this chapter, workplace union representation is typically inserted into a hierarchy of representation characterised by an increasing geographical and organisational scope of representation as one moves towards the national level. The task of coordinating the responses of union structures in different workplaces is typically carried out by regional or national officials. For example, there are no official union structures in Italy that bring together workplace representatives in the public hospital sector on a regular basis in order to discuss issues of mutual concern. In Ireland, the branch structure of the unions offers a means of achieving this, although as I noted earlier, the branch structure of the INO, in particular, is characterised by a high level of routinisation and very low levels of participation.

If we take the tendencies towards 'routinisation' and 'bureaucratisation' seriously, there is clearly a risk that even the most democratic, participatory and proactive workplace structures remain isolated, with minimal influence on the behaviour of their regional and national representatives. In the absence of an obligation to ballot all members on national agreements, for example, the Italian union leadership is effectively unaccountable to the base of the unions. In the context of health service rationalisation, therefore, it is interesting to ask whether it is possible to build upon the sensitivity of the 'representative relationship' to work grievances in order to generate organisational forms that articulate and tackle these grievances at higher levels. At present, there is very little awareness of the importance of such contacts in the Irish case study hospital, and there are no links between the different nursing unions present at hospital level. The following two extracts, from interviews with an INO representative and a PNA representative respectively, illustrate this point:

[225] Gaetano Marati, Interview U-6.

[Researcher: Do you have any contact with the PNA here?] No. (pause) It's the Psychiatric Nurses Association, so (pause) I don't know how the hospital would even... I don't know how receptive they would even be ... because they could argue like, well in some ways they could argue that "well, this is a totally separate thing". But I mean at the same time their issues are very similar, and it's still under the same laws and rules and regulations. ... [Researcher: It just strikes me that there could be a productive group or liaison?] Oh, the PNA wouldn't get together with... [No?] No. They wouldn't, because the INO still has a long way to go before it will be... The PNA are quite militant.[226]

[Researcher: There's no sense in which your experience here could feed back into the hospital as a whole?] No. (pause) I mean I suppose I could, if I put my mind to it to liaise with them better. And I mean I SHOULD, because we have INO members in this Unit. Actually, it's something that I have never thought about.[227]

Summary

In this chapter, I have shown that the detailed study of union representation at local level can shed considerable light on the ways in which nurses relate to their unions and on the influence of various aspects of the social and political context. I began by discussing theoretical frameworks for the study of workplace unionism, emphasising tendencies towards 'routinisation' and 'bureaucratisation' as well as counter-tendencies such as participation, democracy, collectivism and militancy. I pointed out some of the limitations of the existing literature on 'union renewal', emphasising the importance of organisational forms and political traditions. Although workplace participation has the potential to combat tendencies towards routinisation and even corruption at local level, this depends upon the structure of workplace representation and the existence of democratic procedures that facilitate membership participation.

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[226] Female Staff Nurse (34 years of age) and INO representative in *Voluntary Hospital*, Interview 1-10.
[227] Female Ward Sister (32 years of age) and PNA representative in *Voluntary Hospital*, Interview 1-7.

In contrast to health service rationalisation, management strategies and national union responses, there are very marked contrasts between the Irish and Italian case study hospitals as far as the 'representative relationship' is concerned. These contrasts are apparent in relation to nurses' motives for joining a union, their orientations towards the union movement, their evaluation of union representatives and their aspirations regarding workplace representation. By throwing these differences into relief, the comparative analysis of union responses can provide insights into the determinants of union renewal and militancy.

In both Ireland and Italy, the participation of union members has been encouraged at local level by 'bottom-up' and 'top-down' processes of union renewal linked indirectly with health service rationalisation. However, these processes have not produced lasting changes in workplace union organisation and have not yielded visible improvements in the working conditions of hospital nurses. On the one hand, the rationalisation process has made it difficult to obtain improvements in working conditions at local level, as decentralisation has been accompanied by strict limits on spending and staffing levels at the level of central government. Thus, in order to resolve their most urgent grievances, it is apparent that nurses must challenge the principles underlying the rationalisation process as a whole. On the other hand, the participation of union leaders in national structures of concertation has meant that renewal 'from above' has tended to favour workplace structures that are integrated into the hierarchy of union representation in a subordinate fashion. Although the rank-and-file unions in Italy have identified these problems, and have the potential to act as a channel for nurses' dissatisfaction with their work situation, their decision to organise outside the union confederations has facilitated their marginalisation and encouraged the further fragmentation of union representation.

Nevertheless, the fact that nurses in these two countries are starting to question existing union structures and to place greater demands on their representatives is an important development. Attempts by nurses to use collective action as a means of resolving grievances at the local level has the potential to overcome the disillusionment of Italian nurses and the feeling of powerlessness that has tended to characterise Irish nurses. Arguably this will constitute the driving force for union renewal in the future.

Moreover, the experience of the nurses' pay campaign in Ireland and the first national nurses' strike provides a powerful example of the benefits of union militancy. As I have attempted to show in this chapter, traditions of collectivism and democratic union organisation are rooted in nurses' concrete experiences of collective action. Although workplace union organisation remains rather weak in the case study hospitals, the pace of change in nurses' attitudes towards their jobs and towards their unions has been very rapid over the last ten years.

One of the key findings of the research is that much more attention needs to be given to the interface between the labour process and institutionalised forms of union representation. I have suggested that the most important elements that mediate between these two systems are work grievances, on the one hand, and the representative relationship, on the other. The multi-dimensional nature of nurses' work grievances and the importance of non-pay issues related to work organisation, staffing levels and patient care stand in marked contrast to the tendency of union leaders and researchers alike to reduce grievances to wages and wage differentials. By focusing on the ways in which workplace union structures articulate grievances and 'transmit' them to higher levels of the union, it is possible to gain greater understanding of the determinants of the dynamics of union militancy at national level. For this reason, the organisational form of local union structures is a key variable in accounting for union responses to rationalisation, as different forms of unionism differ in how they 'transmit' grievances to the official union structure. One of the benefits of a comparative approach is that it highlights differences in relation to organisational forms and union strategies. For example, this provides a new perspective on 'steward representation' in the Anglo-Saxon countries, which can no longer be treated as a 'natural' form of workplace organisation and enables us to identify the *differentia specifica* of the rank-and-file unions in Italy.

The nexus between work grievances and the representative relationship can also elucidate distinctive patterns of industrial relations at national level. In Ireland, for example, it is apparent that the weakness of workplace union organisation prevents the nursing unions from transmitting the grievances of their members to the national leadership. Because of the weakness of union mediation at local level, there is thus a

tendency for nurses' grievances to 'accumulate'. Not only are grievances not resolved, but they do not even obtain expression at a collective level in many cases. As a result, frustration tends to increase over time, leading to a 'pressure cooker' model of industrial relations. This phenomenon is related primarily to non-pay issues, although the pressure on wages and the inflexibility of the existing 'pay hierarchy' generated by concertative agreements have also contributed to nurses' frustration.

The nurses' pay campaign in Ireland provided a graphic example of the consequences of the 'pressure cooker' model at national level. When union leaders called mass meetings with the aim of strengthening their hand during negotiations, they 'lifted the lid' off the pressure cooker. Although the upsurge in militancy during this period was primarily focused on wages, its origins must be sought in the wider context of nurses' work grievances. As a consequence, to the extent that non-pay grievances remain unaddressed, there is a potential for outbursts of militancy, although it is evident that a relatively high threshold must first be exceeded before Irish nurses are prepared to take industrial action.

In the Italian case study hospitals, in contrast, the multiplicity of union actors present at local level and the high levels of activism and involvement that traditionally characterised health workers' relationship with their unions meant that representatives have tended to remain more closely attuned to their members' grievances, at least until the 1980s. In particular, there is evidence that issues that could be tackled at local level were frequently resolved following the intervention of union representatives, also because the political management of the Italian health service increased pressures to avoid social conflict. Wage grievances were typically tackled at national level, and the competition between rival union confederations, and between the confederations and non-confederal unions, generated considerable pressure for the militant defence of living standards.

During the 1980s and 1990s, however, the decline in participation levels and the strengthening of clientelistic and at times corrupt forms of union organisation at local level altered this picture. Simultaneously, the consolidation of neo-corporatist arrangements at national level reduced the scope for wage increases and encouraged a

further demobilisation of the base of the unions. Whereas in the past, negotiations over contractual renewal often involved regional and even national strikes, this became increasingly rare during the 1990s.

As a result, the ability of workplace union structures in the Italian hospitals to provide a channel for nurses' work grievances has been reduced; the uneven process of union renewal that has occurred in recent years has not had a major impact on this aspect of union representation. There is therefore a possibility that nursing industrial relations in Italy may begin to resemble the 'pressure cooker' model that I described in relation to the Irish health service. This implies that union responses to rationalisation may remain uneven and rather volatile and suggests that the extremely high level of grievances amongst hospital nurses in Italy may lead to an outburst of union militancy in the near future. If this occurs, it is likely that the rank-and-file unions will play a central role in coordinating industrial action by nurses, as was the case for Italian teachers in 1986-88.

VII CONCLUSIONS

Introduction

I will now draw together some of the key points made in previous chapters and present the main findings of my research. In each of the previous chapters, I focused on a single aspect of health service rationalisation, progressing gradually from the macro level to the micro. Although this facilitates a precise analysis of policy change, nurses' work grievances and union responses, it nevertheless makes it more difficult to explore the relationship between these different elements of the overall picture. Furthermore, the decision to discuss work grievances and local union representation towards the end of the thesis means that the wider implications of the trends that I identified are not discussed in detail. The role of this chapter is therefore to build on the preceding analysis by developing more general hypotheses regarding the challenges facing the nursing unions. I will begin by recalling the central research questions and overall design of the study, focusing above all on the comparative approach adopted. I will then summarise the empirical evidence collected during fieldwork and discuss its relevance to each of the research questions.

Perhaps the most important aspect of the overall study design is its comparative focus on welfare state restructuring in Ireland and Italy. Comparative research is often motivated by a desire to identify the underlying mechanisms responsible for observed patterns of behaviour. By studying how different outcomes manifest themselves in situations that are rather similar, it is possible to develop theoretical hypotheses regarding the causal influences responsible for these outcomes. In this thesis I have used structural *similarities* in order to isolate strategic and organisational *differences* in union structures and strategies. By grounding union responses in a study of the 'representative relationship' within the workplace, I developed a set of middle-range theoretical hypotheses that explain broader patterns of industrial relations.

The first step in the construction of the comparative framework involved an analysis of welfare 'regimes' in Europe. Building on suggestions by Clancy et al. (1992), Ferner (1991), Hyman (1994), O'Connell & Rottman (1992) and Simkus et al. (1991), I

compared developments in the Republic of Ireland with a region that is located outside the European 'core'. In fact, the experience of late and uneven industrial development in Ireland has similarities with that of Southern European countries such as Spain, Portugal, Italy and Greece. As such, many of the concepts developed by Italian sociologists in order to account for the specificities of the Italian welfare state (Ferrera, 1996, 1998; Ponzini, 1998) are also applicable to Ireland. In particular, the notion of 'particularism' provides a means of developing a comparative framework for studying peripheral regions within the European Union.

The key features of particularistic welfare states is the weakness of the central state, its permeability to organised interest groups and the predominance of clientelism and familialism over universalistic entitlements. The concept of 'particularism' provides a bridge between the clientelistic relationships observed in Southern Italy and the mixed system of welfare provision in Ireland. In both cases, a 'universalistic' welfare state is eroded from within by particularistic forms of access to, and provision of public health care. Weaknesses inherent in the process of state formation in the European periphery find expression in the greater pertinence of family networks, patron-client relationships and exchange relationships. These relationships play a key role in accessing public welfare services that are ostensibly 'universalistic', and have attained a position of primacy due to the failure of the state to provide effectively for the welfare needs of the population.

This structural similarity distinguishes the peripheral countries of Western, Southern and Eastern Europe from 'core' countries such as Britain, France and Germany. All of the peripheral countries experienced difficulties in 'modernising' their welfare services during the 1970s and 1980s, particularly because recession struck whilst the welfare state was still in the process of construction. The process of European Monetary Union has encouraged policy convergence in these countries, as the criteria for EMU have generated similar pressures for wage restraint, deflationary policies and state restructuring. As a consequence, there are considerable similarities between Ireland and Italy in relation to the structure of interest representation as well as health service rationalisation.

Welfare policy and industrial relations have consequently become closely interlinked in the peripheral countries. This is why Crouch (2000), Hardiman (2000), Hyman (1994), Pochet (1998), Regini (1999), Rhodes (1998) and Teague (1995) link the development of 'social pacts' in these countries with the process of EMU. A distinctive model of neo-corporatism has emerged as a result – what Rhodes (1998) refers to as 'competitive corporatism' – and provides the basis for a comparative analysis of union responses to rationalisation. This implies that we cannot study health service rationalisation in countries such as Ireland and Italy without situating this in the context of wider debates about European Monetary Union, neo-corporatism and economic competitiveness.

Similarities and Differences in Relation to Rationalisation

The evidence presented in this thesis supports the hypothesis of policy convergence within particularistic welfare states in Europe. On the basis of a detailed analysis of health service rationalisation in Ireland and Italy, I showed in Chapter Two that common pressures and a similar structural location within the European Union have given rise to comparable outcomes. Thus, the first significant finding of the research is that policy reform in Ireland and Italy has followed a similar trajectory. In both of these countries, the rationalisation of the public health service was viewed as a precondition for participation in EMU, and after an intense period of cuts in bed numbers and staffing levels in the late 1980s (Ireland) and the early 1990s (Italy), policy makers embarked upon a fundamental reform of the health service.

The main contours of this restructuring were provided by a policy model promoted by the OECD, WHO and EU during the 1990s. This relies on the model of New Public Management, which developed primarily on the basis of the British NHS reforms during the early 1990s, comprising three main elements: managerialism, organisational change and marketisation. Thus, when I refer to 'rationalisation', I am thinking explicitly about these processes, all of which have the aim of increasing the efficiency and value-for-money of public services. In addition to these elements, health service rationalisation involves an assortment of more 'traditional' mechanisms of spending restraint, including central control over budgets, recruitment embargos, service charges and the rationing of treatment.

One of the key questions raised by the rationalisation process in particularistic welfare states is whether the state can actually implement policies based on the New Public Management. As I noted above, this cluster of countries is characterised precisely by the relative weakness of the central state and its permeability to vested interests. The rationalisation process is driven by the need to boost efficiency and seeks to institutionalise pressures for constant improvements in the efficiency and quality of hospital care. The resulting model of managerial rationality stands in marked contrast to the principles upon which public sector management has traditionally relied. For example, in Chapter Four I highlighted the role of political clientelism in Italy in shaping the outlook of hospital managers.

One of the benefits of a comparative approach is that it sheds light on the preconditions for particular kinds of management strategies and behaviours. By analysing management strategies in four different case study hospitals in Ireland and Italy, this thesis provides valuable evidence on the progress of the reforms. In fact, the overall impression gained during fieldwork is that many managers in the South of Italy are unwilling to implement the programme of rationalisation. Given the lack of renewal within the managerial stratum in this part of Italy, it is perhaps unsurprising that an autonomous and strategic form of management has been slow to take shape. On the contrary, many managers remain wedded to their traditional role as political mediators.

Nevertheless, where the balance of political power has been favourable to this outcome, more effective and independent forms of management have emerged in certain hospitals. This was the case in one of the Neapolitan hospitals studied as part of this research project. The dramatic contrast between the outlook of the General Manager of this hospital and that of his predecessors indicates that the health reforms may have created some of the necessary preconditions for a transformation in the role of hospital managers in the South of Italy. However, there are a series of obstacles to this development, which remains confined to a handful of large, acute hospitals.

In contrast to the Italian setting, the response of Irish hospital managers to health service rationalisation has been very positive, and the large acute hospitals have once again played a pioneering role. For example, some Voluntary Hospitals have appointed

managers with a different profile to their predecessors. In the Irish case study hospital, for example, a young manager with a technical and strategic approach to management was appointed by the Board of Management during the mid-1990s. Like his counterpart in the Italian case study hospital *Azienda*, this manager focused on defining and upgrading his hospital's 'core business' in order to develop an effective competitive strategy.

The enthusiastic reaction of managers in the large acute hospitals in Ireland nevertheless conceals at least one potential obstacle to the implementation of health service rationalisation in Ireland. Because the Public Voluntary Hospitals are owned and managed by voluntary organisations, managers tend to have institutional loyalties that lead them to prioritise the interests of their own hospital over wider considerations of equity, efficiency and accountability. The evidence from the Irish case study hospital suggests that this institutional loyalty may encourage managers to behave rather opportunistically, exploiting their market position and capitalising on synergies between the private and public systems. Moreover, the dominant position of the Public Voluntary Hospitals within the Irish health service enables them to externalise some of the costs associated with reform. This could have the unintended effect of reducing the overall efficiency of the health service as well as undermining its governability and accountability.

Impact of Rationalisation on Nurses' Working Conditions

The second research question regards the impact of the rationalisation process on nurses' working conditions, and this was addressed in Chapter Five. Despite striking differences in the gender composition, age profile, labour market situation and marital status of nurses in Ireland and Southern Italy, there are strong similarities in how they describe their working conditions and in the nature of the issues that they identify as problematic. All interview volunteers emphasised the negative impact of health service rationalisation on staffing levels and workloads. Nurses recounted that *aziendalizzazione* in Italy and the rationalisation of health care in Ireland have led to a rapid increase in patient throughput whilst holding staffing levels constant or even reducing them. I showed in Chapter Five that staff shortages and overcrowding have a

negative effect on many other aspects of nursing, including professional status and roles, health and safety issues, the quality of patient care and work relationships. It is worth noting that the increases in workloads that have occurred over the last five or ten years are mainly attributable to 'traditional' forms of rationalisation, such as recruitment embargos, spending limits and hospital closures. Given the difficulties I identified earlier in relation to the implementation of a managerial model based on the New Public Management, these forms of rationalisation are likely to remain in force for the foreseeable future. Thus, the implementation of the health reforms is likely to increase the territorial dualism between the North and South of Italy, with spending limits and recruitment embargos taking the place of strategic management in the South in order to secure improvements in 'value-for-money'.

In response to the second research question, therefore, rationalisation appears to have exacerbated staff shortages by increasing workloads without providing additional staffing resources. One of the most interesting findings of the research is that non-pay issues such as short-staffing are of great concern to nurses, equalling or even outstripping grievances in relation to wage levels and incentives. Although nurses typically balance different aspects of their work situation against each other, the empirical evidence presented in Chapter Five suggests that specific grievances have a considerable 'resilience'. This means that union attempts to channel nurses' frustrations with staff shortages towards wage increases are unlikely to prove satisfactory to nurses in the long term.

Union Responses to Rationalisation

Given the close relationship between state restructuring and concertative bargaining in peripheral regions of the EU, it is perhaps unsurprising to find that the responses of union leaders to health service rationalisation are very similar in Ireland and Italy. This reinforces the hypothesis that social pacts in peripheral regions of the EU share a number of structural similarities (Crouch, 2000; Ferner, 1991; Hardiman, 2000; Regini, 1999; Teague, 1995). It also underlines the relationship between the rationalisation of the public services and the competitive pressures unleashed by European convergence. As I showed in Chapter Three, the unions' acceptance of health service rationalisation

was encouraged by their participation in neo-corporatist bargaining arrangements. Therefore, one of the conclusions of this thesis is that national agreements in Ireland and Italy have ensured the support of union leaders for health service rationalisation.

Although spending cuts and hospital closures provoked protests by union members in Ireland in 1987 and in Italy in 1992, these did not disrupt the rationalisation process. The national strike by Irish nurses posed a more serious challenge, however, due to the high level of militancy that it unleashed, due to the relatively weak commitment of the nursing unions to the Partnership system and because it represented an explicit rejection of incomes policy. Nevertheless, the unions' decision to focus on long-service increments, allowances and differentials reduced this threat. As I showed in Chapter Six, union leaders concentrated their attention on wage increases throughout this period of union militancy, and sought to channel nurses' frustrations with their work situation into support for a pay campaign. The weakness of workplace union organisation amongst Irish nurses contributed to their marginalisation from union decision-making.

Because of the strong similarities between Ireland and Italy in relation to health service rationalisation and national union responses, one of the effects of the comparative approach adopted in this thesis is to highlight differences in workplace union organisation. I showed in Chapter Six that Italian nurses' experiences of democratic and participatory forms of workplace unionism during the 1970s enables them to develop a sophisticated critique of existing forms of representation. In contrast, Irish nurses have little experience of workplace organisation and the structure of workplace representation is very weak in the Dublin case study hospital. The role of representatives is often confined to distributing information and most representatives go no further than 'bringing the issues to the attention of Nursing Management'. Nevertheless, there is evidence that a more assertive group of representatives has emerged in recent years in the context of the increased militancy of the nursing profession.

In both Ireland and Italy, union participation at local level has been encouraged by 'bottom-up' and 'top-down' processes of union renewal. However, these processes have not produced lasting changes in workplace union organisation and have not yielded visible improvements in working conditions. On the one hand, the rationalisation

process has made it more difficult to obtain improvements in working conditions at local level, as decentralisation has been accompanied by strict limits on spending and staffing levels. Thus, in order to resolve their most urgent grievances, it is apparent that nurses must increasingly challenge the principles underlying the rationalisation process as a whole. On the other hand, the participation of union leaders in national structures of concertation has meant that renewal 'from above' has tended to favour workplace structures that are integrated into the hierarchy of union representation in a subordinate fashion.

Given the explanatory power of the analytical approach to work grievances that I developed in Chapter Five, it is rather surprising that Labour Process Theory has given so little attention to this concept. Arguably, much more attention needs to be given to the interface between the labour process and institutionalised forms of union representation within this area of research. I suggested in Chapter Six that the most important elements that mediate between these two systems are work grievances, on the one hand, and the representative relationship, on the other. By focusing on the ways in which workplace union structures articulate grievances and 'transmit' them to higher levels of union representation, it is possible to gain insights into the determinants of more general patterns of unionisation, militancy and participation.

I also showed in Chapter Six that the ability of workplace unionism to act as a vehicle for the expression of grievances depends heavily on the organisational form of local union structures. In fact, this was one of the key themes of Chapter Six, and underlines the fact that organisational forms form part of the 'patrimony' of national union movements. The influence of political traditions within the labour movement is therefore closely related to organisational structures. The latter are crucial not only to the articulation and transmission of grievances but also influence the capacities of unions to tackle these issues by means of collective action at local level.

For these reasons, the form of local union organisation is an important variable in accounting for union responses to rationalisation. In Ireland, for example, the weakness of workplace union organisation prevents the nursing unions from transmitting the grievances of their members to the national leadership. Because of this weakness,

nurses' grievances have a tendency to 'accumulate' at local level, a phenomenon that is encouraged by the occupational culture of deference that has traditionally characterised nursing in Ireland. This is the mechanism underlying the 'pressure cooker' model of industrial relations: grievances are not resolved and frequently do not even find collective expression. As a result, frustration levels tend to increase over time and this creates the conditions for an outburst of militancy.

Despite the politicisation and collectivism of Neapolitan nurses and the sophistication of their attitudes towards workplace representation, the ability of local union structures to provide a channel for nurses' grievances has been curtailed considerably over the past two decades. This is evidenced by the decline in participation levels as well as in union membership rates. There is therefore a possibility that nursing industrial relations in Italy may begin to resemble the 'pressure cooker' model. This implies that union responses to rationalisation may be extremely uneven and volatile in the future. The extremely high level of dissatisfaction expressed by hospital nurses in Naples suggests that an outburst of union militancy may occur in the near future. In this event, the rank-and-file unions are likely to play a role in expressing nurses' anger at their working conditions. It remains open, however, whether the union confederations will be able to renew their workplace structures in order to meet this challenge. In the longer term, an important question is whether nurses can transform existing union structures in order to bring about a closer alignment between their work grievances, on the one hand, and processes of collective organisation, on the other.

APPENDIX A OVERVIEW OF QUESTIONNAIRE SURVEY

Survey Design

In this Appendix, I will provide a detailed description of the survey that was administered in the case study hospitals and explain why a multi-method approach was adopted. Given the aims of the research – to explore the nature of union representation within the hospital context, to evaluate the strategies of hospital managers and to study the responses of the Irish and Italian unions to health service rationalisation – a qualitative approach based on semi-structured interviews was initially identified as the most appropriate research methodology. In particular, I was concerned to situate the behaviour of managers, union representatives and nurses within their social context and to gather information on their strategic outlook and their evaluations of health service rationalisation.

However, a purely qualitative research design would have provided no comprehensive information on the characteristics of the nursing workforce in the case study hospitals. Given the relative lack of sociological research on nursing in Ireland and Southern Italy, the collection of baseline data was considered essential. Although many researchers prefer to begin by conducting exploratory interviews and to move on to a 'confirmatory' phase of quantitative data collection, this can create difficulties in relation to the recruitment of interviewees. For example, 'snowballing' techniques frequently give rise to biased samples due to the likelihood of restricted sampling. At an early stage in the research, it was realised that the circulation of a short questionnaire at the beginning of the field research in each case study hospital had the potential to overcome this problem by generating a quasi-random sample of interview volunteers. The distribution of questionnaires also provided a pretext for meeting nurses in their place of work and carrying out non-participant observation in a relatively unobtrusive manner.

Sampling Strategy

Although the use of a questionnaire to identify interview volunteers helped to overcome one of the main dangers in qualitative research, that of restrictive sampling (Miles & Huberman, 1994: 34), a degree of 'self-selection' is nevertheless apparent in the sample of interviewees, and it is important to understand the consequences of this for the research. Above all, it is apparent that nurses who were involved in professional development, who were active in their union or who were simply interested in discussing hospital work were more likely to volunteer for interviews. Moreover, the Irish sample was much smaller than the Italian sample of interview volunteers, due to time and resource constraints. There is therefore a danger of generalising from this active, relatively eloquent subset of nurses to the workforce as a whole. This tendency was offset, however, by proactive sampling on the part of the researcher and by the use of 'focus group' techniques in the hospital wards. Nurses who were unwilling to be interviewed individually were often content to participate in a group discussion. Thus, where a nurse from a given shift team volunteered for interview, I invited their colleagues to participate in the discussion or (where this was deemed inappropriate) to volunteer for separate interviews. It is likely that the sample of interviewees remains rather biased towards union militants, activists and advocates of professional development, but as these individuals are also very valuable informants, this bias may be considered functional to the aims of the study.

Description of the Case Study Hospitals

All four case study hospitals are large, acute hospitals situated in urban areas, providing a combination of emergency care and elective admissions. The Irish case study hospital accepts a mixture of elective and emergency admissions, and the three Italian hospitals vary in relation to the balance of emergency and elective work, with one hospital accepting only a small number of emergency cases, a second accepting a balance between emergency and elective admissions and the third admitting only a small number of patients for elective treatment. These large, publicly-funded hospitals play an important role within their respective health services, being situated at the apex of the system of health care. For this reason, they are not 'representative' of Irish and Southern

Italian hospitals in general, but were chosen due to their size, status and importance within the hospital system. At the beginning of the research project, the General Managers or Chief Executive Officers of a number of potential case study hospitals were contacted in writing, and a brief discussion took place with all those who replied to this introductory letter. On the basis of these conversations, two case study hospitals were identified in Italy and one in Ireland; a third case study hospital in Naples was subsequently included when an opportunity to extend the data collection process presented itself.

After contact was established with the General Managers or Chief Executive Officers of the case study hospitals, their permission was sought for the distribution of a questionnaire amongst nursing personnel and for the inclusion of an appeal for interview volunteers. In the third Italian case study hospital, *Emergency Block*, a number of Ward Sisters, who had heard about the survey from their colleagues in *Azienda*, offered to assist the researcher by distributing questionnaires in their wards. The permission of Nursing Management was obtained for this research, as the death of the previous General Manager and delays in the appointment of a replacement made it impossible to carry out a hospital-wide survey.

Questionnaire Administration

Once permission was obtained from general management in the three main case study hospitals, the support of nursing management was sought for the distribution and collection of questionnaires. In all cases, this support was immediately forthcoming and Nurse Managers and Unit Nursing Officers showed great willingness to assist with the research. The researcher was introduced to the Ward Sister of each ward in each case study hospital by a nurse manager, and I used this opportunity to explain the aims of the research and the nature of the questionnaire. At each stage in this process, the importance of anonymity was emphasised, and a number of steps were taken to ensure that this anonymity was respected. An envelope was provided with each questionnaire, and completed surveys could be placed in a box in the ward itself or returned to a centrally-located collection point in the hospital. A second envelope was provided so

that interview volunteers could return a volunteer form separately from their questionnaire.

During the initial visit to each ward, those nurses who were on duty were invited to complete the questionnaire immediately and the researcher explained the aims of the research directly. The Ward Sister subsequently distributed questionnaires to each new shift team as they arrived, and the vast majority of questionnaires were completed within the ward, often during a short break from work. After one week, the researcher returned to the ward and collected the completed questionnaires, and the Ward Sister recounted any questions or comments he or she had received. Additional time was provided if a sizeable number of nurses had not had an opportunity to complete the questionnaire.

In the Irish hospital, many nurses expressed a desire to provide more detailed information, and this facilitated the subsequent phase of qualitative research. In the Italian hospital, a more proactive approach was required, both during the distribution of questionnaires and during their completion and collection. In a number of cases, the researcher spent an entire week in a given ward, administering the questionnaire directly and discussing the research with nurses themselves. In many cases, Ward Sisters were unable to participate actively in the research, primarily due to the pressure of work. Given the predominantly 'oral' culture of the Neapolitan hospitals – and nurses' lack of familiarity with attitudinal surveys – a high level of support was required during the compilation of questionnaires. Nevertheless, a number of Italian nurses provided additional comments on the final page of the questionnaire, and these were of great assistance during the analysis stage.

The questionnaire contains five sections that inquire about the individual attributes, employment status, union involvement, work grievances and attitudes of nurses. There are 44 closed questions with multiple response options, 22 of which utilise a Likert rating scale with seven response categories. Space was provided in a number of cases in order to accommodate responses outside the main categories (in relation to union membership in Italy, for example). All question items were designed by the author, after evaluating previous surveys of Irish and Italian nurses (Bordogna, 1994; Power, 1996)

and after consulting a number of methodological texts (Bryman & Cramer, 1990; De Vaus, 1991; Erickson & Nosanchuk, 1992).

Given the pressures of nursing work, and in anticipation of the difficulties involved in questionnaire research in Neapolitan hospitals, a short questionnaire with a limited number of response options was deemed most appropriate. A pilot study was carried out in the School of Nursing in *Azienda* with the assistance of the Nurse Tutors, and approximately twenty student nurses participated. Where appropriate, responses to the pilot study were incorporated into the survey database, although the responses of student nurses were excluded from the main analysis. In addition, Nurse Managers and Tutors were asked to provide comments on an early draft of the questionnaire, and their feedback was incorporated into the final version.

This research design ensured very satisfactory response rates, and 559 questionnaires were completed by Italian nurses and 296 by their Irish counterparts, for a total of 855. The response rates were 42 per cent in *Azienda* (294 responses), 53 per cent in *Presidio* (148 responses) and 51 per cent in *Voluntary Hospital* (296 responses). A total of 117 questionnaires were collected in *Emergency Block*, but due to the nature of the sampling procedure adopted in this hospital, it was not possible to estimate the precise response rate. Given the difficulties posed by complex shift patterns, annual leave and the sheer pressure of nursing work, these response rates are highly satisfactory.

Data entry was carried out using the software programme *Blaise*, which permits logical checks and filters, and all data were checked against the original questionnaires to ensure accuracy. The data were then exported to the statistical package SPSS and all analysis was carried out using version 8 of this programme. Tables, graphs and statistical analysis using the survey data have been incorporated into the text of the thesis where appropriate.

Questionnaire (English Version)

SURVEY QUESTIONNAIRE

For all nurses and nursing students: please complete all sections and return this questionnaire to your Ward Sister or to the collection point specified on the envelope

The Characteristics, Employment Situation and Trade Unions of Hospital Nurses in Ireland

Introduction

This questionnaire is part of a doctoral research project on health service restructuring in Ireland, looking in particular at its implications for hospital nurses. The research is being carried out by Jonathan Pratschke from the Department of Sociology at Trinity College Dublin. The aim of the research is to look at what is changing in the current system of funding and management of public hospitals, and to explore the strategies available to hospital nurses and their trade unions.

Instructions

The questionnaire which follows represents the first stage of research, and contains four sections on the **background and employment status**, **trade union involvement**, **work grievances** and **attitudes** of hospital nurses. Instructions are included at the beginning of each section, and you are kindly requested to answer the questions that follow. Your responses will be used solely to complete this research project and in resulting academic publications. Please note that **this survey is totally confidential**; you are thus requested not to write your name on the questionnaire itself. Thank you for your time and help.

Section I: Biographical Details and Employment Situation

The following questions ask about various personal attributes (age, gender etc.) and about aspects of your work situation and will be used to analyse the questionnaire data. Please tick the relevant box and fill in the information requested.

1. Grade

1		**Student Nurse**
2		**Staff Nurse**
3		**Ward Sister**
4		**Paediatric Nurse**
5		**Nurse Tutor**
6		**Nurse Manager/Matron**

2. Employment Status

1		**Permanent Employee**
2		**Temporary Employee**
3		**Agency Nurse**
4		**Other (please specify)**

3. Ward Type (please tick all options relevant to you)

1		**General Medical Ward**
2		**General Surgical Ward**
3		**Intensive Care Ward**
4		**Day Care Ward**
5		**Operation Theatres**
6		**Accident & Emergency Ward**
7		**Specialist or Other Ward**
		(Please specify)

4. Qualifications (please specify principal qualifications attained)

1		**None**
2		**Reg. General Nurse**
3		**Reg. Mental Handicap Nurse**
4		**Reg. Sick Children's Nurse**
5		**Reg. Psychiatric Nurse**
6		**Reg. Nurse Tutor**
7		**University Degree/Masters**
8		**Other Qualification**
		(Please specify)

5. Gender

1		**Female**
2		**Male**

6. Marital Status

1		**Single**
2		**Married**
3		**Divorced/Widowed**

7. Children

1		**At least one child under 3**
2		**At least one child over 3**
3		**No children**

8.

What is your nationality?

9.

In what year were you born?

10a. (STUDENTS ONLY)

How long have you been studying as a nurse?

years *months*

10b. (NURSING STAFF ONLY)

How long have you been working as a registered nurse?

years *months*

11. (NURSING STAFF ONLY)

How long have you been working in this hospital?

years *months*

12.

On average, how many hours per week do you work in this hospital?

13.

Do you have another paid nursing or non-nursing job outside this hospital?

1 **Yes**

2 **No**

Section II: Work Grievances

The following questions are about problems that you may face in your work environment and your attitude towards them. Please tick the relevant box and fill in the information requested.

14.

Over the last year (or since you began working here) have nurses' working conditions in this hospital improved, remained more or less the same or disimproved?

1 ☐	**Improved**
2 ☐	**The same**
3 ☐	**Disimproved**
9 ☐	**Don't know**

15.

Looking ahead one year from now, do you think working conditions for nurses in this hospital will have improved, remained more or less the same, or disimproved?

1 ☐	**Improved**
2 ☐	**The same**
3 ☐	**Disimproved**
9 ☐	**Don't know**

16.

Please indicate the seriousness, for you, of the work problems listed overleaf.

A series of potential problems are listed on the following page, alongside a scale from one to seven. Please rate the seriousness of these problems in your work by circling the appropriate number (1 = not serious at all; 7 = extremely serious) alongside each problem.

Example:

Problem	*Rating Scale*						
	Not Serious ←						→ *Extremely Serious*
Lack of resources	**1**	**2**	**3**	**(4)**	**5**	**6**	**7**

Circle the number which expresses your view

	Problem	Rating Scale: Not Serious ◄——► Extremely Serious						
1	**Understaffing**	1	2	3	4	5	6	7
2	**Pay Levels**	1	2	3	4	5	6	7
3	**Quality of care**	1	2	3	4	5	6	7
4	**Number of hours worked**	1	2	3	4	5	6	7
5	**Excessive workload**	1	2	3	4	5	6	7
6	**Shift organisation**	1	2	3	4	5	6	7
7	**Lack of career progress**	1	2	3	4	5	6	7
8	**Access to training**	1	2	3	4	5	6	7
9	**Lack of autonomy**	1	2	3	4	5	6	7
10	**Retirement age**	1	2	3	4	5	6	7
11	**Pension entitlements**	1	2	3	4	5	6	7
12	**Lack of resources**	1	2	3	4	5	6	7
	Problem	*Not Serious ◄——► Extremely Serious*						
		Rating Scale						

Do you have other serious work problems not listed above? Please provide a brief description of these problems, continuing overleaf if necessary.

Section III: Trade Union Involvement

The questions in this section ask about the trade unions in this hospital and your (possible) involvement with them. Please tick the box corresponding to your answer or fill in the information requested, to the best of your knowledge.

17.

Are you currently a member of a trade union?

1 ☐ **Yes (continue)**

2 ☐ **No (go to no. 22)**

18.

If so, what trade union do you belong to?

1 ☐ **INO**

2 ☐ **SIPTU**

3 ☐ **IMPACT**

4 ☐ **Other trade union (please specify):** _____

19. (UNION MEMBERS ONLY)

How long have you been a member of this trade union?

years	*months*

20. (UNION MEMBERS ONLY)

How often do you attend the branch meetings of your union?

1 ☐ **Always**

2 ☐ **Often**

3 ☐ **Sometimes**

4 ☐ **Never**

21. (UNION MEMBERS ONLY)

Is there a representative of your trade union in the hospital?

1 ☐ **Yes**

2 ☐ **No**

9 ☐ **Don't know**

22.

What (other) trade unions have you been a member of in the past whilst working as a nurse?

1	☐	**INO**	**For how long were you a member?** _____
2	☐	**SIPTU**	**For how long were you a member?** _____
3	☐	**IMPACT**	**For how long were you a member?** _____
4	☐	**OTHER**	**For how long were you a member?** _____
		(Please specify) _____	
5	☐	**NONE**	

23.

Is there a tradition of trade union membership in your family?

1 ☐ **Yes**

2 ☐ **No**

Section IV: Attitude Towards Nursing Employment

This section contains a series of statements about nursing employment, alongside a scale from one to seven. The scale measures the extent to which you agree or disagree with the statement, ranging from 1 (strongly agree) through 4 (neither agree nor disagree) to 7 (strongly disagree). Please read the statement and circle the number which most accurately reflects your opinion.

24.

	Agree ← → Disagree						
Nurses' expertise and experience are given the respect they deserve by society	1	2	3	4	5	6	7

25.

Nurses will not get a fair deal from the government until they are prepared to fight for it	1	2	3	4	5	6	7

26.

A nurse should not take industrial action which may have a negative impact on patient care	1	2	3	4	5	6	7

Agree ← → Disagree

27.	Agree ← → Disagree						
The nursing profession needs its own representative organisations in order to defend its interests	1	2	3	4	5	6	7

28							
I decided to become a nurse because I wanted to help the sick and injured	1	2	3	4	5	6	7

29.							
Nurses do not gain by adopting a conflictual attitude towards health service managers	1	2	3	4	5	6	7

30.							
Nurses have sufficient autonomy in the performance of their work	1	2	3	4	5	6	7

31.							
Nursing employment is equally suited to both women and men	1	2	3	4	5	6	7

32.							
I decided to become a nurse for economic/employment reasons	1	2	3	4	5	6	7

33.							
Nurse managers/Matrons should not be allowed to join general nursing trade unions	1	2	3	4	5	6	7
	Agree ← → Disagree						

END OF QUESTIONNAIRE

Thank you for taking the time to complete this questionnaire. If you have any questions, or if you would like additional information about this research project, please contact:

Jonathan Pratschke, 27 Greenville Terrace,
Dublin 8 tel/fax: (01) 4540785

Request for Interview Volunteers

I am extremely grateful for the time that you have taken to complete this questionnaire, and would like to inform you of the next phase of research. This will involve **interviews with hospital nurses**, to explore your experience of nursing employment and trade unions in greater detail. The interviews will take roughly **45 minutes**, and can be arranged at your convenience. Participation is voluntary (I would be delighted if you could take part), and confidentiality is assured.

If you are willing to participate, please fill in your name, address and phone number below and return this sheet **separately** to the collection point indicated on the envelope. You may also use this sheet to provide additional comments or to ask any additional questions in confidence.

Name (block capitals please)

_____

Address (block capitals please)

_____

_____

Ward

_____

Phone Number (if available)

_____

Questions/Comments (continue overleaf if necessary)

_____

_____

Questionnaire (Italian Version)

QUESTIONARIO

Per tutti gli infermieri: completare e restituire nella busta fornita

Le caratteristiche, la situazione occupazionale e i sindacati della categoria degli infermieri ospedalieri nell'Italia del Sud

Gentile Signora/Gentile Signore,

Il seguente questionario fa parte di un progetto di ricerca sulla ristrutturazione del servizio sanitario nel Sud Italia. Lo scopo è di comprendere quali saranno le conseguenze di tale mutamento per gli infermieri ospedalieri. La ricerca è svolta da Jonathan Pratschke (Dipartimento di Sociologia e Scienza della Politica dell'Università di Salerno) e cerca di analizzare il sistema emergente di finanziamento e gestione degli ospedali pubblici nel Mezzogiorno, e le strategie che gli infermieri e i loro sindacati possono seguire.

Istruzioni

Il questionario rappresenta il primo stadio di ricerca e contiene quattro parti sulle **caratteristiche e la situazione occupazionale** degli infermieri ospedalieri, le loro **problematiche lavorative, il coinvolgimento nei sindacati**, e **le attitudini** degli stessi. Le istruzioni sono fornite all'inizio di ogni parte e si prega gentilmente di rispondere alle domande che seguono. Le Sue risposte verranno adoperate soltanto per completare questo progetto di ricerca e per le eventuali pubblicazioni scientifiche che ne seguiranno. Si prega di restituire il questionario al punto di raccolta indicato sulla busta fornita.

L'indagine è completamente confidenziale: ha solo scopi scientifici e si assicura la riservatezza delle informazioni. Quindi, non chiediamo di specificare il proprio nome. Si ringrazia per l'aiuto e per il tempo dedicato.

Parte I: Dettagli biografici e situazione occupazionale

Le seguenti domande hanno lo scopo di conoscere i dati personali e la situazione lavorativa degli infermieri al fine di analizzare meglio i risultati del questionario successivo. Si prega di rispondere alle domande o contrassegnando la risposta giusta o dando la risposta per iscritto.

1. Grado occupazionale

1		**Allievo/a**
2		**Infermiere/a Generico/a**
3		**Infermiere/a Professionale**
4		**Vigilatrice d'Infanzia**
5		**Infermiere/a Ostetrico/a**
6		**Caposala**
7		**Dirigente dell'Assistenza Inf.**

2. Posto di lavoro

1		**Reparto di Medicina Generale**
2		**Reparto di Chirurgia Generale**
3		**Reparto Operatorio**
4		**Pediatria/Maternità/Ginecologia**
5		**Poliambulatorio/Day Hospital**
6		**Pronto Soccorso**
7		**Altri Reparti**

3. Qualifiche

1		**Nessuna**
2		**Diploma di Infermiere**
3		**Infermiere Pediatrico**
4		**Infermiere dell'Area Critica**
5		**Altra Specializzazione**

4. Stato di impiego

1		**Impiego fisso**
2		**Contratto di impiego temporaneo**
3		**Infermiere/a sostituto/a**
4		**Altro (specifichi per favore):**

5. Genere

1		**Femminile**
2		**Maschile**

6. Stato civile

1		**Nubile/Celibe**
2		**Sposato/a**
3		**Divorziato/a o Vedovo/a**

7. Figli

1		**Almeno un figlio sotto i tre anni**
2		**Almeno un figlio sopra i tre anni**
3		**Nessun figlio**

8.

Nazionalità:

9.

Anno di nascita:

10a. (Allievi)

Da quanto tempo studia come infermiere?

anni	*mesi*

10b. (Lavoratori)

Da quanto tempo lavora come infermiere?

anni	*mesi*

11. (Lavoratori)

Da quanto tempo lavora in questo ospedale?

anni	*mesi*

12.

In media, quante ore alla settimana lavora in questo ospedale?

13.

Ha un altro lavoro salariato al di fuori dell'ospedale?

1		**Sì**
2		**No**

Parte II: Problematiche lavorative

Le seguenti domande riguardano gli eventuali problemi in ambito lavorativo e il Suo atteggiamento nei confronti di essi. Si prega di rispondere alle domande, o contrassegnando la risposta giusta o dando la risposta per iscritto.

14.

Nel corso dell'anno passato, le condizioni del lavoro degli infermieri sono cambiate in meglio, sono rimaste invariate o sono peggiorate?

1	☐	**Migliorate**
2	☐	**Invariate**
3	☐	**Peggiorate**
9	☐	**Non so**

15.

Secondo Lei, tra un anno, le condizioni lavorative degli infermieri di questo ospedale saranno migliorate, resteranno le stesse o saranno peggiorate?

1	☐	**Migliorate**
2	☐	**Invariate**
3	☐	**Peggiorate**
9	☐	**Non so**

16.

Si prega di indicare qual è, secondo Lei, la gravità dei problemi lavorativi nell'elenco a fronte.

Nella pagina seguente è indicata una serie di problemi potenziali affiancati da una scala che va da uno a sette. Si prega di indicare qual è la serietà di questi problemi, nel Suo lavoro, mettendo un cerchio sul numero appropriato (1 = non grave; 7 = molto grave).

Esempio:

Problema	*Serietà del problema*						
	Non grave ←						→ *Molto grave*
Carenza di risorse	**1**	**2**	**3**	**(4)**	**5**	**6**	**7**

Metta un cerchio sul numero appropriato

	Problema	Serietà del problema Non grave ← → Molto grave						
1	**Carenza di personale**	1	2	3	4	5	6	7
2	**Stipendi**	1	2	3	4	5	6	7
3	**Qualità dell'assistenza**	1	2	3	4	5	6	7
4	**Numero di ore**	1	2	3	4	5	6	7
5	**Lavoro eccessivo**	1	2	3	4	5	6	7
6	**Organizzazione dei turni**	1	2	3	4	5	6	7
7	**Scarsità di promozioni**	1	2	3	4	5	6	7
8	**Accesso alla formazione**	1	2	3	4	5	6	7
9	**Mancanza di autonomia**	1	2	3	4	5	6	7
10	**Età di Pensionamento**	1	2	3	4	5	6	7
11	**Pensioni**	1	2	3	4	5	6	7
12	**Carenza di risorse**	1	2	3	4	5	6	7

Se ci sono problemi gravi che non figurano nell'elenco, può aggiungerli qui sotto.

_____

Parte III: Coinvolgimento nei sindacati

Le domande di questa parte riguardano i sindacati in questo ospedale e il Suo eventuale coinvolgimento con essi. Si prega di rispondere alle domande, o contrassegnando la risposta giusta o dando la risposta per iscritto.

17.

Attualmente è iscritto/a a un sindacato?

1 ☐ **Sì (continua)**
2 ☐ **No (vada a n. 22)**

18.

Se sì, a quale sindacato è iscritto/a?

1 ☐ **CGIL**
2 ☐ **CISL**
3 ☐ **UIL**
4 ☐ **CISAL**
5 ☐ **CISNAL**
6 ☐ **COBAS**
7 ☐ **Altro Sindacato (specifichi per favore):**

_____

19.

Da quanto tempo è membro di questo sindacato?

anni	*mesi*

20.

Partecipa alle riunioni locali del Suo sindacato?

1 ☐ **Sempre**
2 ☐ **Spesso**
3 ☐ **Qualche volta**
4 ☐ **Mai**

21.

C'è un rappresentante del Suo sindacato nell'ospedale?

1 ☐ **Sì**
2 ☐ **No**
9 ☐ **Non so**

22.

Nel passato, mentre lavorava come infermiere/a, è stato/a iscritto/a a qualche sindacato, e se sì, a quali?

1	☐	**CGIL**	4	☐	**CISAL**
2	☐	**CISL**	5	☐	**CISNAL**
3	☐	**UIL**	6	☐	**COBAS**
7	☐	**Altri Sindacati (specifichi per favore):** _____			

23.

C'è una tradizione sindacale nella Sua famiglia?

1	☐	**Sì**
2	☐	**No**

Parte IV: Atteggiamento nei confronti del lavoro

In questa parte sono esposte alcune problematiche legate al lavoro degli infermieri. Una scala da uno a sette misura il grado di accordo o disaccordo con tali affermazioni. Si prega di leggerle con cura e di mettere un cerchio sul numero che esprime più fedelmente il Suo orientamento.

24.

	accordo ← → disaccordo						
La competenza e l'esperienza degli infermieri ricevono la considerazione dovuta dalla società	1	2	3	4	5	6	7

25.

Gli infermieri non riceveranno un trattamento giusto dal governo finché non saranno pronti a lottare per questo	1	2	3	4	5	6	7

26.

L'infermiere non dovrebbe attuare azioni rivendicative che danneggino l'assistenza ospedaliera	1	2	3	4	5	6	7

accordo ← → disaccordo

27.	accordo ← → disaccordo						
La professione infermieristica ha bisogno di organizzazioni proprie per difendere meglio i suoi interessi	1	2	3	4	5	6	7

28							
Ho scelto il lavoro di infermiere/a perché volevo aiutare i malati e feriti	1	2	3	4	5	6	7

29.							
Si trae nessun vantaggio da un atteggiamento conflittuale verso i dirigenti del servizio sanitario	1	2	3	4	5	6	7

30.							
Gli infermieri hanno un livello sufficiente di autonomia nell'adempimento dei loro compiti	1	2	3	4	5	6	7

31.							
Il lavoro infermieristico è adatto sia alle donne che agli uomini	1	2	3	4	5	6	7

32.							
Ho scelto il lavoro di infermiere/a per motivi economico-occupazionali	1	2	3	4	5	6	7

33.							
Ai dirigenti dovrebbe essere proibito iscriversi ai sindacati generali infermieristici	1	2	3	4	5	6	7
	accordo ← → disaccordo						

FINE DEL QUESTIONARIO

Si ringrazia per aver completato il questionario. Non esiti a contattarmi al seguente indirizzo per ulteriori informazioni:

Jonathan Pratschke
Via Nuova Pizzofalcone 35
80132 Napoli
tel/fax (081) 7645928

Invito per un'ulteriore intervista

Sono molto grato per il tempo dedicato al questionario, e vorrei informarLa del prossimo stadio della ricerca. Questo comporterà delle interviste sulle idee degli infermieri nei confronti della ristrutturazione dell'assistenza ospedaliera. Le interviste dureranno circa 45 minuti e potranno avere luogo ad un'ora da Lei decisa. La Sua disponibilità è facoltativa e il carattere confidenziale e riservato dell'intervista è assicurato.

Se Lei volesse prendere parte, si prega di mettere il proprio nome, cognome, indirizzo e numero di telefono qui sotto e di restituire questo foglio (separatamente dal questionario) al punto di raccolta indicato sulla busta fornita. Eventuali domande o osservazioni vanno scritte nello spazio fornito.

Nome e Cognome (stampatello)

_____

Indirizzo (stampatello)

_____

_____

Numero di Telefono

_____

Eventuali domande o osservazioni (può continuare a tergo se necessario)

_____

_____

_____

_____

_____

APPENDIX B ORGANISATION AND ANALYSIS OF INTERVIEW DATA

Selection of Interviewees

In Appendix A I outlined how the survey of nurses in the case study hospitals was carried out and I described how the distribution of a brief questionnaire facilitated the recruitment of interview volunteers for the qualitative stage of the fieldwork. To recapitulate, all nurses who responded to the questionnaire were encouraged to provide their name, address and phone number on a separate sheet of paper that was returned separately to the researcher. In addition, during the distribution of the questionnaires, contact was established directly with a number of nurses, who were invited directly to participate in the research project. In Italy, 87 nurses volunteered to participate in the qualitative stage of the research (this represents 17 per cent of questionnaire respondents), and 29 volunteers came forward in Ireland (11%).

All interview volunteers were contacted by phone either at home or at their place of work and an appointment was arranged. In Italy, roughly half of the interviews were carried out during working hours, primarily during the evening and night shifts, when the pace of work in the wards is somewhat more relaxed. Of the remaining interviews, roughly half were conducted in the interviewee's home and the other half were carried out in the hospital context, either before or after a shift. In the Irish case study hospital, all interviews were carried out in an office provided by Nursing Administration, which was situated outside the main hospital building but within the grounds of the hospital, outside work hours.

Overview of the Interviews

Nearly all interviews took place between 1997 and 1998, although the final two interviews were carried out immediately prior to the national nurses' strike in Ireland in 1999. The interviews were loosely structured and had an average duration of approximately one hour, during which time the discussion ranged from nurses' motives

for choosing their job, their experience of work and their views about work grievances, union representation, hospital management and health service rationalisation. At the beginning of each interview, permission was obtained to record the conversation and an assurance of complete anonymity was provided. In order to safeguard the confidentiality of the interviews, I collected only rudimentary information on the age, gender and union affiliations of the volunteers (see Table B.1 below).

In Ireland, 9 individual interviews and one joint interview (with two nurses) were carried out, for a total of 11 interviews. A total of 29 individual interviews and 7 joint interviews (6 with two nurses and one with three interviewees) were carried out in Italy, which implies that 44 nurses were interviewed in the Italian hospitals. In some cases a brief 'off-the-record' discussion supplemented the recorded interviews with Italian nurses, and the content of these informal conversations has been integrated into the text of this thesis in an indirect manner (in most cases these conversations concerned allegations of corruption in relation to managers or union representatives). The willingness of the interviewees to speak openly about their experience of hospital work and their involvement with the unions reflects their trust in the researcher, and this was of great benefit to the research.

Of the 55 hospital nurses who were interviewed, 11 were elected workplace union representatives, and many of these were approached directly in order to request an interview (these individuals are indicated by an asterisk in Table B.1). When referring to the interviews with hospital nurses and nursing representatives in this thesis, I have used the identification codes included in Table B.1. The interview schedule is included at the end of this Appendix.

In addition to interviewing nurses, I also conducted two interviews with non-nursing workplace representatives, 11 interviews with full-time union officials (7 at national level and 4 at regional level), 6 interviews with hospital managers and health service administrators and one interview with a professional representative from the IPASVI College in Naples (see Table B.2). When referring to the interviews with these individuals in the course of this thesis, I have used the identification codes included in Table B.2.

All interviews with Italian nurses, union representatives and managers were conducted in Italian, and the transcription and analysis were also carried out in the original language. When using extracts from these interviews, I have sought to preserve the sense and fluidity of the original interview when doing the translation. All interviews were transcribed in full (see below for the transcription conventions), and where appropriate, this notation has been included in the extracts.

Transcription Notation

Unfinished phrase:	...
Interruption:	//
Clarifying comments by researcher:	()
Questions and interjections by the researcher:	[]
Emphasis:	BOLD

Table B.1 List of Nursing Interview Volunteers[228]

Hospital/ID Number	Age	Gender	Grade	Current Union	Past Unions	Date
1-1	*42*	*Female*	*Nurse Manager*	*INO*		*15/5/1998*
1-2	*31*	*Female*	*Staff Nurse*	*INO*		*25/11/1998*
1-3	*32*	*Female*	*Ward Sister*	*INO*		*25/11/1998*
1-4	*36*	*Male*	*Nurse Manager*	*INO*		*26/11/1998*
1-5	*25*	*Female*	*Staff Nurse*	*INO*		*27/11/1998*
1-6	*28*	*Female*	*Staff Nurse*	*INO*	*RCN*	*30/11/1998*
1-7	*32*	*Female*	*Ward Sister*	*PNA**	*SIPTU*	*30/11/1998*
1-8	*35*	*Female*	*Ward Sister*	*INO**		*30/11/1998 16/10/1999*
1-9	*42*	*Female*	*Ward Sister*	*INO*		*2/12/1998*
1-10	*approx. 34*	*Female*	*Staff Nurse*	*INO**	*ITGWU*	*2/12/1998*
1-11	*approx. 53*	*Female*	*Nurse Manager*	*INO*		*10/3/1999*

[228] Current hospital union representatives are indicated by an asterisk. Hospital No. 1 is the Irish case study, *Voluntary Hospital*, and No. 2, No. 3 and No. 4 correspond to *Azienda*, *Presidio* and *Emergency Block* respectively.

Table B.1 *Continued*

Hospital/ID Number	Age	Gender	Grade	Current Union	Past Unions	Date
2-1	52	Female	Nurse Manager	UIL	CGIL	23/4/1997
2-2	42	Male	Staff Nurse	CGIL		17/71997
2-3	42	Female	Staff Nurse	None	CGIL CISL UIL	17/7/1997
2-4	47	Male	Staff Nurse	FAPAS	CGIL	18/7/1997
2-5	42	Male	Staff Nurse	None	CGIL	21/7/1997
2-6	49	Male	Staff Nurse	None	UIL	22/7/1997
2-7	42	Female	Staff Nurse	None	CGIL UIL	25/7/1997
2-8	44	Male	Ward Sister	None	CGIL UIL	7/8/1997
2-9	44	Male	Staff Nurse	FAPAS	CGIL	10/8/1997
2-10	34	Female	Staff Nurse	FAPAS	UIL	10/8/1997
2-11	36	Male	Staff Nurse	None	CGIL	13/8/1997
2-12	50	Male	Staff Nurse	None		13/8/1997
2-13	43	Male	Staff Nurse	FAPAS		18/8/1997
2-14	46	Male	Staff Nurse	FAPAS*		18/8/1997
2-15	43	Male	Ward Sister	Aut. Union*	UIL CGIL	20/8/1997
2-16	48	Male	Staff Nurse	None	CGIL	23/8/1997
2-17	33	Female	Staff Nurse	None		23/8/1997
2-18	41	Male	Staff Nurse	None	CGIL	23/8/1997
2-19	41	Male	Staff Nurse	CISL		29/9/1997
2-20	52	Male	Staff Nurse	CISAL*		29/9/1997
2-21	42	Male	Staff Nurse	UIL*	CGIL	6/6/1997
2-22	53	Male	Ward Sister	None	CGIL UIL	2/10/1997
2-23	52	Female	Staff Nurse	CGIL	CGIL CISNAL	2/10/1997
2-24	39	Male	Staff Nurse	CGIL*		3/10/1997

Table B.1 *Continued*

Hospital/ID Number	Age	Gender	Grade	Current Union	Past Unions	Date
3-1	*37*	*Male*	*Staff Nurse*	*None*	*UIL*	*10/9/1997*
3-2	*45*	*Male*	*Staff Nurse*	*CISL**	*CGIL UIL Aut. Union*	*5/8/1997*
3-3	*53*	*Male*	*Staff Nurse*	*None*	*CGIL CISL CISAL*	*13/1/1998*
3-4	*59*	*Male*	*Ward Sister*	*None*	*CGIL*	*14/1/1998*
3-5	*31*	*Female*	*Midwife*	*SOI*[229]	*CGIL*	*14/1/1998*
3-6	*45*	*Female*	*Midwife*	*SOI*	*UIL*	*14/1/1998*
3-7	*36*	*Male*	*Staff Nurse*	*None*	*CGIL UIL FAPAS*	*15/1/1998*
3-8	*54*	*Female*	*Staff Nurse*[230]	*CISAL*	*CGIL UIL*	*15/1/1998*
3-9	*34*	*Male*	*Staff Nurse*	*CGIL*	*CISL UIL*	*20/1/1998*
3-10	*41*	*Male*	*Staff Nurse*	*CGIL*		*21/1/1998*
3-11	*43*	*Male*	*Ward Sister*	*UIL*	*CGIL*	*23/1/1998*
3-12	*44*	*Male*	*Ward Sister*	*UIL*		*23/1/1998*
3-13	*48*	*Male*	*Staff Nurse*[231]	*CGIL*	*CISL*	*26/1/1998*
3-14	*55*	*Female*	*Nurse Manager*	*UIL*		*28/1/1998*
3-15	*29*	*Female*	*Staff Nurse*	*None*		*Summer 97*
3-16	*38*	*Male*	*Staff Nurse*	*None*	*CISAL*	*28/1/1998*
3-17	*42*	*Male*	*Staff Nurse*	*CGIL**		*11/6/1997*
4-1	*45*	*Male*	*Staff Nurse*	*None*	*CGIL*	*22/9/1997*
4-2	*43*	*Male*	*Staff Nurse*	*CGIL*		*24/9/1997*
4-3	*46*	*Male*	*Nurse Manager*	*CGIL**		*15/7/1998*

[229] SOI stands for *Sindacato delle Ostetriche Italiane*, a new category-based union specific to Midwifery.
[230] This nurse is actually a *Puericultrice*, a category that has now been abolished, with responsibility for care of new-born babies.
[231] This nurse is actually an *Infermiere Generico*, a category that has now been abolished, that resembles the Enrolled Nurse in the British context.

Profile of the Interviewees

The average age of the Italian interviewees is 43.8 years, which is only slightly above the average of 42 for the 480 survey respondents who provided a date of birth. One quarter of the Italian interviewees are female, which suggests that male nurses were more likely to volunteer for an interview (31% of survey respondents are female). Three quarters of the Italian interviewees are Staff Nurses, implying that Ward Sisters and Nurse Managers are slightly over-represented (roughly 90% of survey respondents were Staff Nurses).

Table B.2 List of Union Representatives, Managers and Other Interviewees

ID No.	Name	Gender	Position	Organisation	Date
U-1	*Anonymous*	*Female*	*Workplace Union Representative*	*CISL (in* Azienda*)*	*30/9/1997*
U-2	*Giuseppe Cangiamila*	*Male*	*National Secretary*	*CONFAIL-FAILEL*	*5/9/1997*
U-3	*Aldo Baratto*	*Male*	*Regional Secretary*	*CISL - FIST Sanità*	*3/7/1997*
U-4	*Emiddio Castellano*	*Male*	*Regional Secretary*	*CGIL – Funzione Pubb.*	*21/5/1997*
U-5	*Enzo Mazzola*	*Male*	*National Secretary*	*CISAL - Sanità*	*23/1/1998*
U-6	*Gaetano Marati*	*Male*	*Provincial Secretary (Naples) and member of National Council*	*CUB – RdB*	*1/7/1997 & 16/9/1997*
U-7	*Antonio Mari*	*Male*	*Regional Secretary*	*FAPAS*	*3/7/1997*
U-8	*Kevin O'Driscoll*	*Male*	*National Secretary*	*IMPACT – Health Division*	*26/5/1998*
U-9	*Oliver McDonagh*	*Male*	*National Secretary*	*SIPTU Nursing*	*15/3/2000*
U-10	*Mary Power*	*Female*	*Industrial Relations Officer*	*INO*	*20/5/1998*
U-11	*Liam Doran*	*Male*	*Deputy General Secretary*	*INO*	*22/5/1998*
U-12	*Noel Dowling*	*Male*	*National Secretary*	*SIPTU Nursing*	*11/12/1997*
U-13	*Des Kavanagh*	*Male*	*National Secretary*	*PNA*	*25/5/1998*
U-14	*Anonymous*	*Male*	*National Secretary*	*SLAI-COBAS*	*12/4/1997*

Table B.2 ***Continued***

M-1	*Anonymous*	*Male*	*General Manager of* Azienda	Azienda *hospital, Naples*	*14 July 1998*
M-2	*Antonio Oddati*	*Male*	*Public Relations Manager*	*ASL Salerno 2*	*16/5/1997 & 2/6/ 1997*
M-3	*Anonymous*	*Male*	*Chief Executive Officer of* Voluntary Hospital	Voluntary Hospital, *Dublin*	*9/11/2000*
M-4	*Gerard Barry*	*Male*	*Chief Executive Officer*	*Health Service Employers Agency*	*14/11/2000*
M-5	*Anonymous*	*Male*	*Public Relations Manager*	*ASL Napoli 1*	*17/6/1997 & 11/9/1997*
M-6	*Anonymous*	*Male*	*Health Director of* Presidio	Presidio *hospital, Naples*	*28/1/1998*
P-1	*Michela Rizzello*	*Female*	*President*	*IPASVI College Campania Region*	*11/6/1997*

The average age of the Irish interviewees is 35.5 years, which is considerably higher than the average for the survey respondents (30.6 years). This difference is due, at least in part, to the over-sampling of Ward Sisters and Nurse Managers within the Irish sample of interviewees, and was unavoidable given the small sample size.

Analysis of Interview Transcripts

In contrast to the less 'structured' analytical techniques often utilised by social anthropologists, I adopted a relatively 'codified' and 'formalised' approach, with the aim of building on existing theoretical work and developing theoretical hypotheses with high explanatory power. This stance is incompatible with 'inductive' research strategies which emphasise intuition and tacit assumptions/decisions. Thus, when coding the interviews, I adopted a tentative, a priori and hierarchical coding scheme. The coding scheme was *tentative* because the categories were refined during subsequent coding and analysis, *a priori* because an initial structure was specified on theoretical grounds and *hierarchical* because more specific concepts were grouped under more general ones (Richards & Richards, 1995; cf. Lazarsfeld & Barton, 1972). More general codes, such as 'working conditions', represent meta-codes or 'pattern' codes which group together a number of primary codes, used primarily during the analysis of coded segments. The

basic unit of analysis was the *phrase*, and where multiple themes were covered in a single phrase, overlapping code identifiers were used. In general, two to eight codes were associated with each extract, and all phrases considered relevant to the research questions were coded.

This theory-driven approach was adopted in opposition to the *grounded theory* method developed by Anselm Strauss and his collaborators (Strauss & Corbin, 1990, 1997, 1999; cf. Bryman & Burgess, 1994; Denzin & Lincoln, 1994; Kau & Richards, 1994; Kelle, 1995; Miles & Huberman, 1994). This decision was taken due to the problematic assumption implicit in 'grounded theory analysis', namely that theoretical ideas emerge more or less spontaneously as a result of close involvement with empirical data alone. Glaser (1992) provides an even more rigorously 'inductive' version of 'grounded theory' analysis, arguing that all predefined concepts should be excluded from the analysis. For proponents of 'grounded theory' analysis, theories are constructed by seeing whether initial attempts at categorisation fit the data and by linking together successively broader concepts. This inductive approach has a long history, early exponents including Becker (1958) and Zelditch (1962), and suggests that recurrent phenomena can be discovered in the midst of the 'stream of experience'. The analysis of recurrent relationships between phenomena enables the researcher to formulate working hypotheses, which are gradually refined during the course of the analysis. Thus, the final theory emerges in a piecemeal and inductive fashion.

The feasibility of this approach has been called into question by recent developments in the philosophy and methodology of the social sciences, which have led to a growing realisation that theoretical development involves the *transformation* of existing theories, assumptions and common-sense ideas rather than theoretical creation *ex nihilo* (cf. Archer, 1995; Bhaskar, 1979; A. Sayer, 1992, 1997, 2000). For example, Van Maanen (1979, 1988) points out that what are often referred to as 'facts' or 'data' never speak for themselves, but should be thought of as 'first-order concepts'. Social science theories may therefore be considered 'second-order concepts' which seek to explain the patterning of the first-order concepts.

It therefore makes little sense to suggest that researchers can begin their analysis without bringing with them a panoply of assumptions regarding their area of study. Unless one adopts a critical attitude towards these inherited ideas, the categories which result from 'grounded theory analysis' are likely to be shaped by unquestioned assumptions rather than by the particular texts under scrutiny. As Miles & Huberman (1994) point out, "[a] near-library of research evidence shows that people (researchers included) habitually tend to overweight facts they believe in or depend on, to ignore or forget data not going in the direction of their reasoning, and to 'see' confirming instances far more easily than disconfirming instances…" (1994: 253).

Arguably, the only way of minimising this danger is to make one's assumptions explicit from the very beginning, to question these assumptions repeatedly, to aim for a comprehensive coding scheme and to follow explicit decision rules during the coding process. In this way, any gaps or omissions in the classification scheme utilised during coding will quickly become apparent – particularly if the views of other researchers are obtained – and the necessary adjustments can be made before coding begins. If coding takes place without this rigorous procedure, the danger of overlooking 'inconvenient' patterns or phenomena and of imposing implicit preferences on the data is arguably much greater.

The coding scheme utilised during the analysis phase of this research is reproduced in the table below. To the left of the table, the eight 'Root' codes are indicated in upper-case text (Actions, Actors, Attributes, Contexts, Ideas, Mechanisms, Relationships, Systems). A series of codes are 'nested' within each of these (e.g. collective actions, individual actions, interpersonal actions), and each of these sub-codes can have 'families' of identifiers at lower levels (Control, Intervene, Lead etc.). The codes used during the analysis of the interview data are highlighted in boldface, and the number of extracts coded is indicated between brackets (e.g. 49 extracts were coded with the sub-code 'Control').

When analysing work grievances, extracts were retrieved that corresponded to a combination of codes (e.g. Grievance (867) & Wages (255)), and the resulting extracts were transformed into matrices[232] prior to the preparation of each chapter (see Chapter Five). Where appropriate, 'exemplary extracts' were used to illustrate a particular point, and the relative incidence of different types of response were used to evaluate their representativeness and to identify 'extreme cases'.

Table B.3 Coding Scheme Utilised During Analysis of Interview Data

ACTIONS		
Collective action	<is an>	Action
Control (49)	<is a>	Collective Action
Intervene (162)	<is a>	Collective Action
Lead (54)	<is a>	Collective Action
Negotiate (175)	<is a>	Collective Action
Organise (188)	<is a>	Collective Action
Participate (180)	<is a>	Collective Action
Represent (515)	<is a>	Collective Action
Resist (570)	<is a>	Collective Action
Individual action	<is an>	Action
Family Activities (80)	<is an>	Individual Action
Plan (46)	<is an>	Individual Action
Work (418)	<is an>	Individual Action
Interpersonal action	<is an>	Action
Appoint (260)	<is an>	Interpersonal Action
Join (135)	<is an>	Interpersonal Action
Mislead (28)	<is an>	Interpersonal Action
Talk (100)	<is an>	Interpersonal Action
ACTORS		
Employee (245)	<is an>	Actor
Auxiliary (68)	<is an>	Employee
Doctor (238)	<is an>	Employee
Nurse (1545)	<is an>	Employee
Government (111)	<is an>	Actor
Management (744)	<is an>	Actor
Political Party (105)	<is an>	Actor
Patient (439)	<is an>	Actor
Professional Association (30)	<is an>	Actor
Union Official (118)	<is an>	Actor
Union Member (228)	<is an>	Actor
Union Rep. (529)	<is an>	Actor
Union (662)	<is an>	Actor
Autonomous Union (56)	<is a>	Union
General Union (188)	<is a>	Union
Professional Union (189)	<is a>	Union
Rank-and-file Union (103)	<is a>	Union

[232] A data matrix is simply a tabular array of data – in this case, qualitative data from interviews – in which the cells in the table contain information on the case, contextual data or a truncated quotation or summary.

Table B.3 *Continued*

ATTRIBUTES		
Conditions (154)	<is an>	Attribute
Material Condition (99)	<is a>	Condition
Facilities (23)	<is a>	Material Condition
Hours (116)	<is a>	Material Condition
Leave (21)	<is a>	Material Condition
Risk (55)	<is a>	Material Condition
Wages (255)	<is a>	Material Condition
Workload (241)	<is a>	Material Condition
Professional Condition (224)	<is a>	Condition
Autonomy (141)	<is a>	Professional Condition
Grade (78)	<is a>	Professional Condition
Status (50)	<is a>	Professional Condition
Physical (39)	<is an>	Attribute
Gender (71)	<is a>	Physical Attribute
Psychological (64)	<is an>	Attribute
Culture (166)	<is a>	Psychological Attribute
Quality (216)	<is a>	Psychological Attribute
Resources	<is an>	Attribute
Individual Resource (198)	<is a>	Resource
Capacity (269)	<is an>	Individual Resource
Material Resource (329)	<is a>	Resource
Organisational Resource (416)	<is a>	Resource
Roles (471)	<is an>	Attribute
Interest (229)	<is part of>	Role
Power (114)	<is part of>	Role
Responsibility (88)	<is part of>	Role
Task (89)	<is part of>	Role
Type (530)	<is an>	Attribute
CONTEXTS		
Geographical (22)	<is a>	Context
City (65)	<is a>	Geographical Context
Europe (15)	<is a>	Geographical Context
Hospital (247)	<is a>	Geographical Context
Nation (100)	<is a>	Geographical Context
Region (115)	<is a>	Geographical Context
Ward (77)	<is a>	Geographical Context
Occupational (4)	<is a>	Context
Nursing (410)	<is an>	Occupational Context
Organisational (44)	<is a>	Context
Administration (94)	<is an>	Organisational Context
Hospital Organisation (467)	<is an>	Organisational Context
Health Service (78)	<is an>	Organisational Context
Ward Organisation (502)	<is an>	Organisational Context
Sectoral Context (9)	<is a>	Context
Personal (128)	<is a>	Sectoral Context
Political (289)	<is a>	Sectoral Context
Private (172)	<is a>	Sectoral Context
Public (97)	<is a>	Sectoral Context
Time (701)	<is a>	Context

Table B.3 *Continued*

IDEAS		
Emotions (29)	<is an>	Idea
Anger (129)	<is an>	Emotion
Disappointment (45)	<is an>	Emotion
Pride (66)	<is an>	Emotion
Motives (234)	<is an>	Idea
Altruism (33)	<is a>	Motive
Group-advancement (62)	<is a>	Motive
Improve Conditions (91)	<is a>	Motive
Service Improvement (67)	<is a>	Motive
Organisational Advance. (20)	<is a>	Motive
Self-advancement (33)	<is a>	Motive
Self-realisation (51)	<is a>	Motive
Self-enrichment (37)	<is a>	Motive
Opinions (672)	<is an>	Idea
Negative Evaluation (1017)	<is an>	Opinion
Grievance (867)	<is a>	Neg. Eval.
Orientation (691)	<is an>	Opinion
Positive Evaluation (468)	<is an>	Opinion
Principles (55)	<is an>	Idea
Correctness (150)	<is a>	Principle
Democracy (125)	<is a>	Principle
Efficiency (223)	<is a>	Principle
Equality (156)	<is a>	Principle
Fairness (43)	<is a>	Principle
Professionalism (119)	<is a>	Principle
Solidarity (73)	<is a>	Principle
Strategy (213)	<is an>	Idea
MECHANISMS (101)		
RELATIONSHIPS (9)		
Asymmetrical (6)	<is a>	Relationship
Authority (219)	<is an>	Asymmetric Relationship
Clientelistic (264)	<is an>	Asymmetric Relationship
Deferential (37)	<is an>	Asymmetric Relationship
Exploitative (23)	<is an>	Asymmetric Relationship
Oppressive (58)	<is an>	Asymmetric Relationship
Representative (280)	<is an>	Asymmetric Relationship
Therapeutic (89)	<is an>	Asymmetric Relationship
Symmetrical (3)	<is a>	Relationship
Affectionate (52)	<is a>	Symmetric Relationship
Antagonistic (156)	<is a>	Symmetric Relationship
Collaborative (102)	<is a>	Symmetric Relationship
Cooperative (40)	<is a>	Symmetric Relationship

Table B.3 *Continued*

SYSTEMS		
Aziendalizzazione (470)	<is a>	System
Care (515)	<is a>	System
Competition (96)	<is a>	System
Education (214)	<is a>	System
Healthcare (253)	<is a>	System
Incentives (84)	<is a>	System
Legal (228)	<is a>	System
Media (21)	<is a>	System
'Partnership' (58)	<is a>	System
Religion (33)	<is a>	System
RSU (36)	<is a>	System
Bribery (108)	<is a>	System
Unemployment (144)	<is a>	System

As Miles & Huberman (1994: 10) argue, qualitative research should respect the local groundedness, richness and holism of qualitative data during analysis as well as during data collection. To this end, extensive notes were taken during coding to record the developing ideas of the researcher: "[A memo is] the theorising write-up of ideas about codes and their relationships as they strike the analyst while coding ... it can be a sentence, a paragraph or a few pages ... it exhausts the analyst's momentary ideation based on data with perhaps a little conceptual elaboration" (Glaser, 1978: 83-4). Prior to analysis, automated collation techniques were used to gather together all extracts relating to a given theme.

My aim throughout the analysis was to generate causal hypotheses describing 'generative mechanisms' (Archer, 1995; Bhaskar, 1979; 1998) which could plausibly have given rise to the patterns detected in the empirical data: "Qualitative analysis, with its close-up look, can identify mechanisms, going beyond sheer association. It is unrelentingly local, and deals well with the complex network of events and processes in a situation. It can sort out the temporal dimension, showing clearly what preceded what, either through direct observation or retrospection. It is well equipped to cycle back and forth between variables and processes – showing that 'stories' are not capricious, but include underlying variables, and that variables are not disembodied, but have connections over time" (Miles & Huberman, 1994: 147).

Interview Schedule for Hospital Nurses

Introduction:

- Thank volunteers for completing questionnaire and for volunteering for interview
- Explain aims of interview: gather richer, more detailed information about wards, work grievances, experience of trade unions, changes in recent years
- Request permission for taping interview and assure confidentiality

1. *Access to and choice of nursing as a career*

- How did you become a nurse and why did you choose this career?
- How did you gain access to a nursing qualification and to this job?
- Did you have to use personal or political contacts to achieve these goals?
- What considerations influenced your decision to become a nurse?
- Are any other members of your family nurses?

2. *Experience of nursing*

- How has nursing work changed since you began working?
- How many different hospitals have you worked in and what were the main differences between them?
- How many different wards have you worked in and what are the main differences between them?

3. *Organisation of nursing work*

- How would you describe your work relations with your Senior Consultants, Ward Sisters, Hospital Doctors and Auxiliaries? What are the main problems you encounter?
- How would you describe your work relations with your nursing colleagues in the ward? What are the main problems you encounter in this respect?
- What are the main problems you face in your work?
- How do nurses in your ward think about nursing, what is their attitude towards the profession?
- Are nurse's professional aspirations given sufficient respect?
- How is work organised between nursing, medical, technical and auxiliary staff? Are the responsibilities of each group clearly defined? Are there any areas where changes are needed?

4. *Trade union involvement*

- Are you a member of a union? What is your union and when did you join?
- What were your main reasons for choosing to join a union and for choosing this union in particular?
- Were you a member of a different union in the past? Why did you join this previous union, and why did you choose to leave it?
- Do you come into contact with your union, and what form does this take (e.g. circulars, notices, personal contacts, meetings)?
- How do you participate in the activities of your union?
- Are you happy with the way your union represents you?
- Do you think your union is sufficiently independent and confident in its dealings with hospital management?
- Are there any particular issues that you think your union should take up?
- What do you think of the other unions in the hospital?
- Would you prepared to take industrial action in an attempt to improve working conditions for nurses in this hospital? What types of action? Would you be prepared to go on strike for better conditions or higher wages? Are you worried about the effect on patient care that such action may have?
- If you are not in a trade union, why did you decide not to join? What type of trade union would you join? What kinds of trade union structures are necessary?
- Is a trade union necessary for nurses?

5. *Hospital restructuring*

- What aspects of nursing work have changed in recent years?
- How do you think conditions for hospital nurses will change in the next few years?
- Are you aware of current processes of restructuring? What is the nature of these processes? What are their consequences for nurses?
- How would you describe the current management team in this hospital?
- What are the main priorities for nurses at present? How should they go about pursing their goals?
- What action is needed at the union level?
- What policies or actions are needed at the political level?
- What is the relationship between the political system and the hospital?
- How can health care be improved in your opinion?

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