

VARIETIES OF TRADE UNION MEMBERSHIP POLICIES FROM A MULTI-SCALAR PERSPECTIVE: EVIDENCE FROM THE GERMAN AND BRITISH HOSPITAL SECTORS

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I. INTRODUCTION

This article addresses trade union membership policies in the hospital sector and contrasts the situations in the United Kingdom and Germany, countries with different varieties of capitalism. It draws on industrial relations scholarship that is interested in the diversity of modern capitalist economies and their industrial relations institutions.¹ Departing from a macro-social perspective, these studies revealed the important insight that trade union strategies and practices are influenced by national institutions, but not fully determined by them. This article is also inspired by social movement literature that has developed a perspective on micro-social processes and emphasizes the importance of union actors' identities and framing processes.² Yet, we assume that union membership policies can neither be solely explained by macro-determinants such as the institutions of national political economies nor by a focus on trade unions as entrepreneurial actors in shaping their own destinies. This article instead deals with the tensions and contradictions that exist between industrial relations actors' behavior on the one hand and socio-economic structures and institutions on

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1. See FRANZ TRAXLER, SABINE BLASCHKE & BERNHARD KITTEL, NATIONAL LABOUR RELATIONS IN INTERNATIONALIZED MARKETS: A COMPARATIVE STUDY OF INSTITUTIONS, CHANGE, AND PERFORMANCE (2001); Lucio Baccaro, Kerstin Hamann & Lowell Turner, *The Politics of Labour Movement Revitalization: The Need for a Revitalized Perspective*, 9 EUR. J. INDUS. REL. 119 (2003); Colin Crouch & Wolfgang Streeck, *Introduction: The Future of Capitalist Diversity*, in POLITICAL ECONOMY OF MODERN CAPITALISM: MAPPING CONVERGENCE AND DIVERSITY 1 (Colin Crouch & Wolfgang Streeck eds., 1997); Carola Frege & John Kelly, *Union Strategies in Comparative Context*, in VARIETIES OF UNIONISM: STRATEGIES FOR UNION REVITALIZATION IN A GLOBALIZING ECONOMY 181 (Carola Frege & John Kelly eds., 2004).

2. JOHN KELLY, RETHINKING INDUSTRIAL RELATIONS: MOBILISATION, COLLECTIVISM AND LONG WAVES (1998); Ian Greer & Marco Hauptmeier, *Political Entrepreneurs and Co-Managers: Labour Transnationalism at Four Multinational Auto Companies*, in 46 BRIT. J. INDUS. REL. 76 (2008).

the other hand. The key to understanding union membership policies is therefore, first, the knowledge of the varying and often competing institutional logics and social relations within which trade union practices and strategies are embedded. Second, a perspective is required that sees trade unions themselves as actors that have (historically) enforced and maintained certain institutions at different spatial scales that in turn determine their membership policies.³

Against the background of the internationalization of markets, the fragmentation of organized labor and the politics of liberalization and privatization, national institutions of industrial relations have partly lost their formative influence on trade union behavior. While the varieties of capitalism/unionism approaches assume homogeneity of national institutions across various institutional spheres, this article adopts a multiscalar perspective and posits that trade union action is institutionally embedded on multiple spatial dimensions. These spatial dimensions or scales—to use the more common notion derived from human geography⁴—are seen not as ontologically given, but rather as outcomes of social conflicts over the appropriateness and legitimacy of practices.⁵ Practices are conceived of as relatively stable patterns of action or “shared routines of behavior.”⁶ Moreover, these spatial scales, such as local, sectoral, national, regional, and global, are seen as interlinked in various ways rather than as hierarchical levels of action. Such a multiscalar perspective allows a better understanding of the structural and behavioral determinants of trade union action.

The orientation of this article is explorative and aims at opening up a theoretical perspective that helps achieve a deeper understanding of trade union behavior. It addresses the question: Under what conditions are trade unions more or less likely to maintain or change their membership policies? Industrial relations in the United Kingdom, for instance, are often associated with decentralized structures of collective bargaining, an absence of state support for extension clauses and thus, a dependence by trade unions on membership recruitment and mobilization.⁷ However, in contrast to the private sectors of the economy, trade unions in the British hospital sector can rely on corporatist structures and practices of collective wage setting. These

3. ANDREW HEROD, *LABOR GEOGRAPHIES: WORKERS AND THE LANDSCAPES OF CAPITALISM* (2001); *INSTITUTIONAL WORK: ACTORS AND AGENCY IN INSTITUTIONAL STUDIES OF ORGANIZATIONS* (Thomas B. Lawrence, Roy Suddaby & Bernard Leca eds., 2009).

4. See generally Martin Hess, “*Spatial*” Relationships? Towards a Reconceptualization of Embeddedness, 28 PROGRESS HUM. GEOGRAPHY 165 (2004).

5. See Stefanie Hürtgen, *Labour as a Transnational Actor, and Labour's National Diversity as a Systematic Frame of Contemporary Competitive Transnationality*, 38 CAP. & CLASS 211, 216 (2014).

6. Richard Whittington, Completing the Practice Turn in Strategy Research, 27 ORG. STUD. 613, 619 (2006).

7. Carola Frege & John Kelly, *Union Revitalization Strategies in Comparative Perspective*, 9 EUR. J. INDUS. REL. 7 (2003).

provide them with institutional power and, thus, a functional equivalent to associational power. Germany, by comparison, with its corporatist tradition exhibits a diffuse pattern, ranging from widely intact practices of wage bargaining coordination in manufacturing to more decentralized and fragmented industrial relations in the service sectors, such as health care.⁸ German trade unions in the hospital sector have created new policies (so-called “conditional collective bargaining”) that link their readiness to enter into collective bargaining with their success in organizing (new) members and, thus, in increasing their membership levels. These changes in membership policies can be interpreted as a response to employers’ and state actors’ strategies aimed at weakening formerly existing sector-wide collective agreements.

The article is structured as follows. The next section outlines our theoretical concept on the determinants of trade union behavior. The overall structure and institutions of German and British industrial relations at the national scale are dealt with in Section III. In the following section, the wider institutional and structural environments of industrial relations in the hospital sector in both countries are presented. Section V summarizes our empirical findings, based on seventeen problem-centered interviews with trade union officials in the United Kingdom and Germany and the analysis of documents issued by social partners and state actors. The last section discusses the findings and presents conclusions.

II. A MULTI-SCALAR PERSPECTIVE ON TRADE UNION MEMBERSHIP POLICIES

Comparative political-economic approaches and literature on the varieties of unionism and labor movement revitalization are alike in that they focus on the linkage between national institutions and the strategic behavior of industrial relations actors, such as firms and trade unions.⁹ Since supportive institutions of trade unions can be primarily found at the national level, varieties in trade union strategies have been largely assigned to country-level characteristics of industrial relations.¹⁰ Since in liberal market

8. See Anke Hassel, *The Paradox of Liberalization—Understanding Dualism and the Recovery of the German Political Economy*, 52 BRIT. J. INDUS. REL. 57 (2014).

9. See VARIETIES OF CAPITALISM: THE INSTITUTIONAL FOUNDATIONS OF COMPARATIVE ADVANTAGE (Peter A. Hall & David Soskice eds., 2001); COMPARATIVE EMPLOYMENT RELATIONS IN THE GLOBAL ECONOMY (Carola Frege & John Kelly eds., 2013); TRADE UNIONS IN WESTERN EUROPE: HARD TIMES, HARD CHOICES (Rebecca Gumbrell-McCormick & Richard Hyman eds., 2013); Baccaro, Hamann & Turner, *supra* note 1.

10. See THOMAS A. KOCHAN, HARRY CHARLES KATZ & ROBERT B. MCKERSIE, THE TRANSFORMATION OF AMERICAN INDUSTRIAL RELATIONS (1986); THE BRAVE NEW WORLD OF EUROPEAN LABOR: EUROPEAN TRADE UNIONS AT THE MILLENNIUM (Andrew Martin & George eds., 1999); Baccaro, Hamann & Turner, *supra* note 1.

economies (such as the United Kingdom) collective bargaining coverage is more closely tied to membership levels, it is argued that it makes sense for unions to concentrate on recruitment initiatives and organizing.¹¹ In contrast, unions in coordinated market economies (such as Germany or Italy) can rely at least partly on supportive institutions and political relations at the national level and are therefore less inclined to invest in recruitment and organizing. These institutional approaches highlight enduring institutional differences across countries; however, they tend to overlook within-country variations and institutional changes over time.¹² Moreover, the cross-country comparative perspective that is inherent in the Varieties of Unionism approaches perceives transnational regional (e.g., European) and global changes, such as the global diffusion of certain beliefs (e.g., the supremacy of policy models of liberalism) or increasing international competition, primarily as external factors that put pressure on national trade unions. Thus, the transformative power wielded by local and national industrial relations actors at the regional and global scale is widely neglected.

In order to better understand the behavior of trade unions toward their members, we utilize an analytical concept of space that rejects the notion of established independent levels of action.¹³ Mentalities, perceptions, and behavior of actors are not understood as inevitably bound to (homogeneous) national institutions, but rather viewed as simultaneously embedded within institutions and social relations at different spatial scales. As Sassen argues, the global and the national are usually presented as excluding each other, however “the global economy to a large extent materializes in national territories.”¹⁴ A relational concept of geographical and social space is therefore more appropriate in an increasingly expanding social world.

A relational mode of spatial thinking also helps to better understand the power relationships between industrial relations actors. In drawing on concepts of social space by the French sociologist Pierre Bourdieu, two views on the social world can be differentiated, that is, the objectivist (structuralist) and subjectivist (voluntarist).¹⁵ While the objective (power) positions are linked to the material and symbolic resources they provide, the subjective

11. Baccaro, Hamann & Turner, *supra* note 1, at 131.

12. See Marco Hauptmeier, *Institutions are What Actors Make of Them—The Changing Construction of Firm-Level Employment Relations in Spain*, 50 BRIT. J. INDUS. REL. 737 (2012).

13. See also HEROD, *supra* note 3; Susanne Pernicka, *Einleitung [Introduction]*, in HORIZONTAL EUROPAISIERUNG IM FELD DER ARBEITSBEZIEHUNGEN [HORIZONTAL EUROPEANIZATION OF THE LABOR RELATIONS FIELD] 1 (Susanne Pernicka ed., 2015) (Ger.); Martin Heidenreich et al., *Europäische Vergesellschaftungsprozesse: Horizontale Europäisierung zwischen nationalstaatlicher und globaler Vergesellschaftung [European Socialization Processes: Horizontal Europeanization Between the Nation-State and Global Socialization]* (DFG Res. Unit of Horizontal Europeanization, Working Paper No. 2012-01) (Ger.).

14. SASKIA SASSEN, *A SOCIOLOGY OF GLOBALIZATION* 1, 73 (2007).

15. Pierre Bourdieu, *Social Space and Symbolic Power*, 7 SOC. THEORY 14 (1989).

position includes the perspectives and the points of view that agents have on this reality by virtue of their position in objective social space.¹⁶ Hence, the effectiveness of power resources in shaping industrial relations institutions is also contingent on their (perceived) legitimacy. The basic form of legitimate power in capitalist economies relates to the power to control the means of production, i.e., economic power, which lies in the hands of capital owners and top management. On the side of labor, two basic types of power are differentiated: structural and associational power.¹⁷ Structural power consists of the power that accrues to workers “simply from the location of workers within the economic system.”¹⁸ Tight labor markets or the occupation of a strategic position within the production system, for instance, strengthen the bargaining position of labor vis-à-vis employers. Associational power, in comparison, consists of “the various forms of power that result from the formation of collective organization of workers” (most importantly trade unions and political parties).¹⁹ A third type of power that was introduced later into the debate is institutional power.²⁰ Institutional power derives from regulatory, normative, and cultural-cognitive institutions that strengthen (or weaken) trade union action in relation to employers. From a perspective that is characterized by a spatial sensitivity we need to take account of the variety of power relationships at different scales and ask whether or not these have an effect on trade union perceptions and behavior.

III. THE VARIETY OF INDUSTRIAL RELATIONS IN GERMANY AND THE UNITED KINGDOM

Until the early 1990s, highly coordinated industrial relations in Germany were an integral part of the German model of capitalism.²¹ Industrial relations actors were embedded into a corporatist system of interest representation and national political decision-making that endowed the interest associations with considerable institutional power. With the internationalization of markets, competitive pressures intensified since the 1980s. Structural changes, such as the growth of the low-wage and service

16. *Id.* at 18.

17. Erik Olin Wright, *Working-Class Power, Capitalist-Class Interests, and Class Compromise*, 105 AM. J. SOC. 957, 962 (2000).

18. *Id.* at 962.

19. *Id.* at 962.

20. See ULRICH BRINKMANN ET AL., STRATEGIC UNIONISM: AUS DER KRISE ZUR ERNEUERUNG DER GEWERKSCHAFTEN? UMRISSE EINES FORSCHUNGSPROGRAMMS [STRATEGIC UNIONISM: FROM CRISIS TO RENEWAL? OUTLINE OF A RESEARCH-PROGRAM] (2008) (Ger.); Susanne Pernicka & Vera Glassner, *Transnational Trade Union Strategies Towards European Wage Policy: A Neoinstitutional Framework*, 20 EUR. J. INDUS. REL. 317 (2014).

21. See Wolfgang Streeck, *German Capitalism: Does it Exist? Can it Survive?*, in POLITICAL ECONOMY OF MODERN CAPITALISM: MAPPING CONVERGENCE AND DIVERSITY 33 (Colin Crouch & Wolfgang Streeck eds., 1997).

sectors as well as the relocation, outsourcing, and off-shoring of production and services either across national borders or regions and sectors, have thoroughly affected industrial relations. National institutions partly lost their integrative function and employers felt more empowered and legitimized to reorient their behavior toward the logic of international market competition. At the same time, trade unions were weakened in terms of both institutional as well as associational power resources. Trade union membership density declined from above 30% in 1992 to below 18% in 2013.²² The decline in collective bargaining coverage indicates the fragmentation and disorganization of industrial relations.²³ While around 70% of employees in western Germany were covered by collective agreements (54% in eastern Germany) in 2003, it was 60% in 2013 (47% in eastern Germany). Besides, structural labor market changes, disorganization, and fragmentation have also resulted from changes in practices of industrial relations actors. For instance, the practice to extend collective agreements to the entire sector was largely abandoned since the late 1990s and employers' strategies of undercutting pay rates settled in sectoral collective agreements, tariff flight and pressing for opening clauses that allow a temporary derogation from sectoral collective agreements became more widespread.²⁴

In the United Kingdom, industrial relations are to a large extent decentralized and disorganized. Collective bargaining takes place mostly at the level of companies or plants. Individual bargaining between workers and management is widespread. Multi-employer bargaining is prevalent in large parts of the public sector, but of limited relevance in the private sector. Only around 30% of employed persons are covered by a collective agreement. In the public sector, collective bargaining coverage is markedly higher, that is, around 64% in comparison with the private sector (17%).²⁵ After having reached its peak of almost 70% in the late 1970s, union density steadily

22. Jelle Visser, *ICTWSS Database Version 5.0*, AMSTERDAM INST. ADVANCED LAB. STUD. (Nov. 2015), <http://www.uva-aias.net>.

23. See WOLFGANG STREECK, RE-FORMING CAPITALISM: INSTITUTIONAL CHANGE IN THE GERMAN POLITICAL ECONOMY (2010); Reinhard Bispingk & Reinhard Bahnmüller, *Abschied vom Flächentarifvertrag? Der Umbruch in der Deutschen Tariflandschaft und Seine Konsequenzen für eine Betriebsorientierte Tarifpolitik* [Farewell to Flächentarifvertrag? The Upheaval in the German Collective Bargaining Landscape and its Consequences for a Business-Oriented Collective Bargaining Policy], in WOHIN TREIBT DAS TARIFSYSTEM? [WHITHER THE COLLECTIVE BARGAINING SYSTEM?] 9 (Reinhard Bispingk ed., 2010) (Ger.); Anke Hassel, *The Erosion of the German System of Industrial Relations*, 37 BRIT. J. INDUS. REL. 483 (1999).

24. See Hartmut Seifert & Heiko Massa-Wirth, *Pacts for Employment and Competitiveness in Germany*, 36 INDUS. REL. J. 217 (2005).

25. DEPARTMENT FOR BUSINESS, INNOVATION & SKILLS [hereinafter BIS], BIS/14/P77, TRADE UNION MEMBERSHIP 2013: STATISTICAL BULLETIN (2014), https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/313768/bis-14-p77-trade-union-membership-statistical-bulletin-2013.pdf.

declined; it dropped from 38.6% in 1989 to 24.7% in 2014.²⁶ With sector-level bargaining lacking in the private sector and legal procedures for the extension of collective agreements being absent, collective bargaining coverage fell in line with union density. Collective bargaining is also often hampered by the unwillingness of employers to recognize trade unions in the workplace. Without supportive industrial relations institutions at the national scale, but with widespread employer hostility and volatile state policies (depending on the political party in government), membership-oriented policies are crucial for trade unions in Britain and have a strong tradition (including the public sector).

IV. THE HEALTH CARE SECTORS IN GERMANY AND THE UNITED KINGDOM

A. *The Health Care Sector in Germany*

One characteristic of the German health system is that it is, to a large extent, financed by the statutory health insurance (installed in the 1880s under Chancellor Bismarck) that, in turn, is funded by income-related contributions of employers and employees.²⁷ As these contributions are part of the labor costs, they have increasingly been viewed as an obstacle to the competitiveness of the German economy, and, since the beginning of the 1990s, several reforms were implemented to remedy this.²⁸ Financing of hospitals in Germany has also undergone profound reforms. The principle of reimbursement for all costs incurred was given up successively and today hospitals are reimbursed on the basis of “diagnosis related groups” (DRG), that implies that they can make profits and losses.²⁹

Hospitals in Germany are run by different providers: public (mostly municipal), non-profit (churches and welfare associations), and private.³⁰

26. BIS, BIS/15/300, TRADE UNION MEMBERSHIP 2014: STATISTICAL BULLETIN (2015), https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/431564/Trade_Union_Membership_Statistics_2014.pdf.

27. See Reinhard Busse & Annette Riesberg, *Gesundheitssysteme im Wandel: Deutschland [Healthcare Systems in Transition: Germany]*, 6 GESUNDHEITSSYSTEME IM WANDEL [HEALTHCARE SYS. IN TRANSITION] i, 70 (2005) (Ger.).

28. See Thomas Gerlinger, *Gesundheitsreform in Deutschland: Hintergrund und Jüngere Entwicklungen [Health Reform in Germany: Background and Recent Developments]*, in 20 JAHRE WETTBEWERB IM GESUNDHEITSWESEN: THEORETISCHE UND EMPIRISCHE ANALYSEN ZUR ÖKONOMISIERUNG VON MEDIZIN UND PFLEGE [20 YEARS OF COMPETITION IN HEALTHCARE] 35 (Alexandra Manzei & Rudi Schmiede eds., 2014) (Ger.).

29. *Id.*

30. See Torsten Brandt & Thorsten Schulzen, Liberalisation and Privatisation of Public Services and the Impact on Labour Relations: A Comparative View from Six Countries in the Postal, Hospital, Local Public Transport and Electricity Sectors, Privatisation of Public Services and the Impact on Quality, Employment and Productivity [PIQUE] 1, 111 (2007), http://www.pique.at/reports/pubs/PIQUE_028478_Del8.pdf.

However, the historically diverse structure of providers has recently undergone significant changes. The share of private hospitals more than doubled from the beginning of the 1990s until 2013 (from about 15% to almost 35%); since 2009, there have been more private than public hospitals, with the share of non-profit hospitals remaining rather stable.³¹ In a European comparison, Germany takes the lead with regard to the extent of material privatization of hospitals, that is, the sale of hospitals to private investors.³² Beside this process of material privatization, measures of formal (organizational and management reforms, change of legal form) and functional (public-private partnerships, outsourcing) privatization have also been taken to increase competitiveness and introduce private sector management practices into public and non-profit hospitals.

With its 5.2 million employees, the health care sector is one of the most important sectors of the German economy (1.2 million are working in hospitals) and employment is growing. However, one has to note the high proportion of part-time work: in 2013, almost 50% of the employees in German hospitals, excluding doctors, were working on a part-time basis.³³ Researchers and unionists see this as a manifestation of strategies of flexibility and cost cutting and also as a response to the high stress levels and workload of employees in health care.³⁴ Due to unfavorable working conditions and pay unionists observe a shortage of qualified personnel, especially in rural regions.³⁵

B. The Health Care Sector in the United Kingdom

The design of the British health system (the National Health Service—NHS) is based on concepts of the social policy reformer William Beveridge (the namesake of the so-called “Beveridge System”). The tax-financed system was implemented after World War II to ensure access to health services for all citizens regardless of their employment status. The universal

31. See STATISTISCHES BUNDESAMT [FEDERAL OFFICE OF STATISTICS], FACHSERIE 12, SERIE 6.1.1, GESUNDHEIT: GRUNDATEN DER KRANKENHÄUSER [HEALTHCARE: BASIC DATA OF THE HOSPITALS] (2014) (Ger.).

32. Ian Greer, Thorsten Schulten & Nils Böhlke, *How Does Market Making Affect Industrial Relations? Evidence from Eight German Hospitals*, 51 BRIT. J. INDUS. REL. 215 (2013).

33. See STATISTISCHES BUNDESAMT, *supra* note 31.

34. MICHAEL SIMON, DER DEUTSCHE PFLEGERAT E.V. [GER. NURSING COUNCIL E.V.], BESCHÄFTIGTE UND BESCHÄFTIGUNGSSTRUKTUREN IN PFLEGEBERUFEN: EINE ANALYSE DER JAHRE 1999 BIS 2009; STUDIE FÜR DEN DEUTSCHEN PFLEGERAT [EMPLOYEES AND EMPLOYMENT STRUCTURES IN THE NURSING PROFESSION: AN ANALYSIS OF THE YEARS 1999 TO 2009; STUDY FOR GERMAN NURSING COUNCIL] 1, 3 (2012) (Ger.).

35. See Interview 02 with Federal Administration Official, Ver.di (May 29, 2013) (on file with author); Interview 03 with Federal Administration Official, Ver.di (June 11, 2013) (on file with author); Interview 05 with Federal Administration Official, Ver.di (Nov. 4, 2013) (on file with author).

access to health care the NHS provides is still held in high esteem by the British.³⁶

The NHS has more than 1.6 million employees. Nurses are the largest occupational group in the NHS.³⁷ Despite an increase in employment since 2003,³⁸ the number of nurses per 1,000 inhabitants is still lower than that in Germany (8.8 compared with 11.5 in 2013) and union representatives observe a shortage of health care personnel.³⁹ According to unionists, this circumstance is partly masked by the increasing number of agency and bank nurses (with rapidly rising costs for the NHS).⁴⁰ Like in Germany, work intensification can be observed in the British hospital sector, for example, because of an increase in administrative tasks.⁴¹

In the United Kingdom private hospitals' share in acute beds is below 10%.⁴² Despite reforms to introduce more competition into the system, it is estimated that private-sector involvement in NHS-service provision currently amounts to about 19%; 12.3% of government secondary care expenditure go to private providers.⁴³ While there has been widespread material privatization in the German hospital sector, formal and functional privatization is predominant in the United Kingdom (although a distinction between the different forms is sometimes difficult to draw). An instrument widely used in the British hospital sector is the "private finance initiative." It draws on private capital to secure funding for new investments (e.g., building of new hospitals).

The NHS is strategically led and financed by the Department of Health, but successively the NHS hospitals were given more independence from the government, first by transforming them into NHS Trusts and later Foundation Trusts, which is granting them more financial and managerial autonomy. The trusts have to compete with each other (and private providers) for

36. See, e.g., BRITISH SOCIAL ATTITUDES: THE 27TH REPORT (Alison Park et al. eds. 2003).

37. See *Under the NHS in England: About the National Health Service (NHS)*, NAT. HEALTH SERVICE [hereinafter NHS], <http://www.nhs.uk/NHSEngland/thennhs/about/Pages/overview.aspx>.

38. ROYAL COLLEGE OF NURSING [hereinafter RCN], RCN LABOUR MARKET REVIEW PUB. NO. 004 740, AN UNCERTAIN FUTURE: THE UK NURSING LABOUR MARKET REVIEW 2014, 1, 4 (2014), http://www.rcn.org.uk/_data/assets/pdf_file/0005/597713/004_740.pdf.

39. See *Health Workforce*, WORLD HEALTH ORGANIZATION [hereinafter WHO], http://gamapserver.who.int/gho/interactive_charts/health_workforce/NursingMidwiferyDensity/atlas.html.

40. See RCN, PUB. NO. 004 823, FRONTLINE FIRST: RUNAWAY AGENCY SPENDING (2015), http://www.rcn.org.uk/_data/assets/pdf_file/0005/608684/FF-report-Agency-spending_final_2.pdf.

41. See, e.g., Jörg Flecker et al., Summary Report, Privatisation of Public Services and the Impact on Quality, Employment and Productivity [PIQUE] 1, 92 (2009), http://www.pique.at/reports/pubs/PIQ_UUE_SummaryReport_Download_May2009.pdf.

42. Séan Boyle, *United Kingdom (England): Health System Review*, 13 HEALTH SYS. TRANSITION 1, 174 (2011) (citing figures for 2007).

43. Nick Krachler & Ian Greer, *When Does Marketisation Lead to Privatisation? Profit-Making in English Health Services after the 2012 Health and Social Care Act*, 124 SOC. SCI. & MED. 215, 215 (2015).

commissions to provide health care services.⁴⁴ The market-enhancing reforms of health care provision were started by the Conservative government in the 1980s and 1990s. The newly elected Labour government (1997) continued to implement reforms to reorganize the NHS by introducing market mechanisms and competition into the system. Currently, the NHS is under great pressure to cut costs. Against the background of the recent European fiscal and debt crisis, the British government pursues a strict course of public austerity.⁴⁵

C. Industrial Relations Institutions and Practices in the German Hospital Sector

In the hospital sector, the United Services Union (ver.di) is the most important organization representing employees.⁴⁶ In health care, membership figures have slightly increased in recent years. Organizational density is estimated to be around 23% in public hospitals and it tends to be lower in private for-profit hospitals and lowest in private non-profit hospitals.⁴⁷ Other than ver.di, a few unions affiliated to the Christian Trade Union Confederation and the union confederation representing civil servants (dbb Beamtenbund & Tarifunion) are organizing workers in health care.⁴⁸ There are also associations representing church employees. Doctors are mainly organized in the professional union “Marburger Bund” that terminated its bargaining cooperation with ver.di in 2005 to negotiate a separate, more favorable agreement for their members resulting in a rise in membership numbers. The association is organizing around 80% of all employed doctors. On the side of employers, associations representing the municipalities (VKA) and the tariff community of the federal states (TdL) are negotiating collective agreements for workers in public hospitals.⁴⁹ Private hospitals are organized mainly in the Association of German Private Clinics (BDPK). Furthermore,

44. See RICHARD POND, LIBERALISATION, PRIVATISATION AND REGULATION IN THE UK HEALTH CARE SECTOR/HOSPITALS: COUNTRY REPORT ON LIBERALISATION AND PRIVATISATION PROCESSES AND FORMS OF REGULATION, PIQUE 1, 5 (2006), http://www.pique.at/reports/pubs/PIQUE_CountryReports_Health_UK_November2006.pdf.

45. Krachler & Greer, *supra* note 43, at 217.

46. See VEREINTE DIENSTLEISTUNGSGEWERKSCHAFT [VER.DI] [UNITED SERVICES UNION], MEHR VON UNS IST BESSER FÜR UNS ALLE: GESCHÄFTSBERICHT FACHBEREICH 3, 1.JANUAR 2011 BIS 31. DEZEMBER 2014 [MORE OF US IS BETTER FOR ALL OF US: ANNUAL REPORT DEPARTMENT 3, JANUARY 1, 2011 TO DECEMBER 31, 2014] (2015) (Ger.).

47. Damian Grimshaw et al., *Convergent and Divergent Country Trends in Coordinated Wage Setting and Collective Bargaining in the Public Hospitals Sector*, 38 INDUS. REL. J. 591, 600 (2007).

48. Der dbb, DBB BEAMTENBUND & TARIFUNION, <http://www.dbb.de/der-dbb.html> [hereinafter DBB].

49. See *infra* Table 1.

there are organizations representing confessional hospitals or other health care institutions.⁵⁰

Industrial relations were affected by reforms of collective bargaining in the public sector. Until 2003, collective actors at the levels of the central state, the federal states, and the communities carried out collective bargaining together. Since the conflictual negotiations over a reform of the public sector collective agreements in the mid-2000s, however, the collective bargaining landscape became more fragmented, with one agreement for employees of the central state and the communities (TVöD), another one for employees of the federal states (TV-L), and several agreements for doctors. Bargaining coverage in the hospital sector is estimated to be around 80% for medical personnel but considerably lower for non-medical staff.⁵¹

Pay and working conditions have become even more diverse due to opening clauses in public sector agreements and the de-coupling of private hospitals from standards set in the public sector. In confessional hospitals, collective labor law and agreements are not applicable, which makes it hard for unions to get access to church employees. While formerly pay and working conditions in these hospitals were oriented toward public sector standards, in recent years an increasing deviation from public sector conditions was observed.⁵² As far as private hospitals are concerned, the association of private clinics withdrew from collective bargaining in 1993. Since then, the national collective agreement for private hospitals with ver.di (and its predecessors) was not renewed. The BDPK negotiated a sectoral framework agreement with Christian unions not affiliated to the German Trade Union Confederation, to implement lower standards than those settled by ver.di. However, the labor courts decided that two of these unions were not eligible to negotiate collective agreements.⁵³ Ver.di has negotiated

50. See Birgit Beese & Sandra Vogel, *Representativeness of the European Social Partner Organisations: Hospitals—Germany, Comparative Information to EurWORK: European Observatory of Working Life*, EUROFOUND (Apr. 27, 2009) <http://www.eurofound.europa.eu/eiro/studies/tn0802017s/de0802019q.htm>; Birgit Kraemer, *Germany: Industrial Relations in the Health Care Sector, Comparative Information to EurWORK: European Observatory of Working Life*, EUROFOUND (Feb. 13, 2011), <http://www.eurofound.europa.eu/eiro/studies/tn1008022s/de1008029q.htm>.

51. See Interview 01 with Federal Administration Official, Ver.di (May 29, 2013) (on file with author).

52. BERNDT K. KELLER, ARBEITSPOLITIK IM ÖFFENTLICHEN DIENST: EIN ÜBERBLICK ÜBER ARBEITSMÄRKTE UND ARBEITSBEZIEHUNGEN [LABOR POLICIES IN THE PUBLIC SECTOR: AN OVERVIEW OF LABOR MARKETS AND INDUSTRIAL RELATIONS] (sigma ed. 2010) (Ger.); Thorsten Schulten & Nils Böhlke, *Die Privatisierung von Krankenhäusern in Deutschland und ihre Auswirkung auf Beschäftigte und Patienten [The Privatization of Hospitals in Germany and Its Impact on Workers and Patients]*, in PRIVATISIERUNG VON KRANKENHÄUSERN: ERFAHRUNGEN UND PERSPEKTIVEN AUS SICHT DER BEŞCHÄFTIGTEN [PRIVATIZATION OF HOSPITALS: EXPERIENCES AND PERSPECTIVES FROM THE PERSPECTIVE OF EMPLOYEES] 97 (Nils Böhlke et al. eds., 2009) (Ger.).

53. See VERA GLASSNER, SUSANNE PERNICKA & NELE DITTMAR, HANS-BÖCKLER-STIFTUNG [HANS-BÖCKLER FOUNDATION] STUDY NO. 306, ARBEITSBEZIEHUNGEN IM KRANKENHAUSSEKTOR [LABOR RELATIONS IN THE HOSPITAL SECTOR] (2015), <http://www.boeckler.de/5248.htm?produkt=HBS-006246&chunk=1&jahr=2015>.

collective agreements in some of the largest private hospital companies, but was unsuccessful in setting standards comparable to those applied in the public sector.⁵⁴

Table 1
Actors of Industrial Relations in the German Hospital Sector⁵⁵

	Membership
<i>Unions</i>	
Ver.di	2.04 million (health and social care: ca. 370,000)
dbb Beamtenbund and Tarifunion	1.28 million
Marburger Bund	117,000
Unions affiliated to the Christian Union Federation	280,000
<i>Employers' Associations</i>	
VKA	650 municipal hospitals, 450,000 employees in hospitals
TdL	30 university hospitals and 8-10 psychiatric hospitals
BDPK	450 member companies, about 248,000 employees in hospitals

D. Industrial Relations Institutions and Practices in the British Hospital Sector

With regard to the determination of pay and working conditions, sector-wide coordination is firmly established in the NHS. In the public sector, pay of workers in some sectors and for particular professional groups, such as doctors and nurses, is settled in so called “pay review bodies” (PRB). These are staffed with independent experts who advise the government on pay, employment, and other sectoral developments. While no collective bargaining about wages in the strict sense is taking place in the public health

54. See Gabriele Gröschl-Bahr & Niko Stumpfögger, *Krankenhäuser [Hospitals]*, in EUROPA IM AUSVERKAUF. LIBERALISIERUNG UND PRIVATISIERUNG ÖFFENTLICHER DIENSTLEISTUNGEN UND IHRE FOLGEN FÜR DIE TARIFPOLITIK [EUROPE ON SALE: LIBERALIZATION AND PRIVATIZATION OF PUBLIC SERVICES AND ITS IMPACT ON COLLECTIVE BARGAINING] 165 (Torsten Brandt et al. eds., 2008) (Ger.).

55. Bundesarbeitsgericht [BAG], June 11, 2013, 1 ABR 33/12, http://juris.bundesarbeitsgericht.de/zweitesformat/bag/2015/2015-01-22/1_ABR_33-12.pdf; Beese & Vogel, *supra* note 50; DBB, *supra* note 48; DGB *Mitgliederzahlen ab 2010*, DEUTSCHER GEWERKSCHAFTSBUND [DGB], <http://www.dgb.de/uber-uns/dgb-heute/mitgliederzahlen/2010/>; DHV—Die Berufsgewerkschaft e.V, DIE BERUFGEWERKSCHAFT E.V [DHV], <http://www.dhv-cgb.de/>; Kraemer, *supra* note 50; Der Marburger Bund, MARBURGER BUND, <http://www.marburger-bund.de/der-marburger-bund/>; Ver.Di, *supra* note 46.

sector, the PRB's recommendations for pay increases are based on evidence provided by labor, employer, and government representatives.⁵⁶

The wage setting system in the NHS was subject to several reforms. The first major reforms in the early 1980s were achieved by interventions in the system of pay determination in the public sector when the newly elected conservative government aimed to contain inflation and curb public expenditures. After protests of professional groups such as nurses, the government established the pay review body for nurses, midwives, and other health professionals in 1983, which was extended to cover all NHS staff except doctors and dentists in 2007. This removed pay setting for nurses from direct collective bargaining and introduced a form of "arm's length bargaining."⁵⁷ At the turn of the century, one of the most important reforms was the so-called "Agenda for Change" (AfC) (2004) that resulted in a harmonization of pay scales for NHS-professions.⁵⁸ Non-wage conditions are settled between employee, employer, and department of health representatives in the NHS Staff Council, which is also responsible for maintenance of the AfC. Some more specific conditions are also settled at local level between the trade unions and the management of hospital trusts. In private hospitals, pay and working conditions are set either between individual workers and management, or, in companies with organized workforces, between local union and management representatives. Collective bargaining coverage in the public health care sector (that is, the national agreement for the NHS sets terms and conditions, while pay is recommended by the PRB and implemented by government decision) reaches 100% while it is considerably lower among workers employed in private hospitals.⁵⁹

In the British health care sector, three general unions (Unison, Unite, and GMB) and two professional unions (The Royal College of Nursing, RCN, and the British Medical Association, BMA) are most relevant regarding the representation of employees.⁶⁰ Unison is the second largest union in the United Kingdom and mainly organizes public sector workers. Among the general unions, Unison organizes the largest number of workers in the health care sector.⁶¹ Unite is Britain's largest trade union and organizes

56. Stephen Bach, Rebecca Kolins Givan & John Forth, *The Public Sector in Transition, in THE EVOLUTION OF THE MODERN WORKPLACE* 307 (William Brown, Alex Bryson & Keith Whitfield eds., 2009); Grimshaw et al., *supra* note 47.

57. Stephen Bach, *A New Era of Public Service Employment Relations: The Challenges Ahead*, ACAS FUTURE OF WORKPLACE RELATIONS DISCUSSION PAPER SERIES, Aug. 2011, at 1, 13.

58. See Manuela Galetto & Paul Marginson, *Industrial Relations and Changing Governance in the Hospitals Sector in the United Kingdom in the 2000s*, GUSTO PROJECT WP6 PAPER (2011).

59. Flecker et al., *supra* note 41; Thomas Prosser, *UK: Industrial Relations in the Health Care Sector, Comparative Information to EurWORK: European Observatory of Working Life*, EUROFOUND (Feb. 13, 2011), <http://www.eurofound.europa.eu/eiro/studies/tn1008022s/uk1008029q.htm>.

60. See *infra* Table 2.

61. Prosser, *supra* note 59.

workers in almost all sectors. The RCN is a professional union organizing qualified nursing staff. It is the most important trade union for nurses and carries out collective bargaining and supports its members in educational and training matters. The BMA organizes doctors and dentists in the public and private sector. On the side of employers, all NHS hospitals are currently affiliated with the employers' association NHS Employers.⁶² NHS Employers represents its members' interests in collective bargaining, recruitment, and employment policies. The managers are represented in the association "Managers in Partnership." Trade union density is high in the public health sector and is estimated to be between 48%⁶³ and 58%.⁶⁴ However, in contrast to other segments of the public sector, such as public administration and education, trade union density was declining in health care from 85% to 48% between 1980 and 2004.⁶⁵ For private hospitals, estimates about trade union density are lacking. Although from a long-term perspective, trade union density is constantly declining in the United Kingdom (i.e., from 29.5% in 2001 to 25% in 2013), in the health and social work sector it has remained stable since 2008, i.e., at around 40%.⁶⁶ The stabilization of membership in health care is perceived to be the result of trade unions' organizing efforts.⁶⁷ The organizational strength of the RCN is outstanding; about 80% of all nurses in the NHS are members of the professional trade union. Similarly, the British Medical Association provides both collective bargaining as well as services specific to the profession. Organizational density of the BMA is around 60%.⁶⁸

Trade unions and employer representatives in the NHS are endowed with institutional power by their integration in the highly centralized pay setting system. Furthermore, trade unions and NHS Employers are holding seats in several tripartite consultative committees to discuss broader sector policies and reforms of the NHS. Norms and practices of coordinated and consensus-oriented collective bargaining are firmly entrenched among representatives of labor and management in the public health care sector. However, the government's practice to adopt pay increases recommended by the PRB was disrupted at the onset of the European fiscal crisis when pay

62. See Helen Newell, *Representativeness of the European Social Partner Organizations: Hospitals—United Kingdom in the Health Care Sector, Comparative Information to EurWORK*, EUROFOUND (Apr. 27, 2009), <http://www.eurofound.europa.eu/eiro/studies/tn0802017s/uk0802019q.htm>.

63. Bach, *supra* note 57.

64. POND, *supra* note 44.

65. Bach, Givan & Forth, *supra* note 56.

66. BIS, *supra* note 25.

67. Bach, Givan & Forth, *supra* note 56; Interview 11 with National Official, Unison (Nov. 10, 2014) (on file with author); Interview 17 with Former National Official, Unison (Jan. 21, 2015) (on file with author).

68. GLASSNER, PERNICKA & DITTMAR, *supra* note 53.

freezes were implemented in the public sector by unilateral state decision. Public austerity was met by the resistance of both trade unions and employers. The recent pay-setting round was more conflictual and trade unions repeatedly organized strikes and protests.

Table 2
Actors of Industrial Relations in the British Hospital Sector⁶⁹

Abbreviation	Name	Members
<i>Employee Organizations</i>		
Unison	Public Service Workers' Union	Around 450,000 employees in NHS and private service providers, thereof 225,000 nurses
Unite	Unite the Union	Around 100,000 members in health care sector, approx. 22,000 nurses
GMB	Britain's General Trade Union	Around 100,000 members in health care sector, approx. 85,000 nurses in hospitals and care homes for older people
RCN	Royal College of Nursing	420,000 members (2014), thereof approx. 320,000 in NHS
BMA	British Medical Association	170,000 members (including medical students, 2016)
<i>Employers' Associations</i>		
NHS Employers		All hospitals (both NHS Trusts and Foundation Trusts)

69. BRITISH MEDICAL ASSOCIATION [BMA], BMA BRIEFING: LORDS DEBATE ON MOTION TO ANNUL SECTION 75 REGULATIONS 24 April 2013 (2013), <https://www.bama.org.uk/collective-voice/policy-and-research/nhs-structure-and-delivery/reconfiguration-and-integration/choice-and-competition/section-75-briefing>; *Monitor*, GOV.UK, <https://www.gov.uk/government/organisations/monitor>; Newell, *supra* note 6, at 21; Prosser, *supra* note 59; *Work for Us*, RCN, http://www.rcn.org.uk/aboutus/working_for_the_rcn.

V. MEMBERSHIP POLICIES IN COMPARISON

A. Germany

Traditionally, German unions have been less concerned with member recruitment than unions in Anglo-Saxon countries. On the one hand, they had less reason for recruitment efforts as membership of German unions was much more stable in the 1980s than in most other OECD countries.⁷⁰ On the other hand, German unions enjoyed high levels of institutional power. Their influence was more due to recognition by the state than due to their own organizational power.⁷¹ This has ambivalent consequences: since organizational power was (to a large extent) substituted by institutional power, the membership losses of the German unions, which gained momentum in the 1990s, were noted but the unions did not really take action against it. The unions' reliance on institutional power had widened the distance between them and their constituencies.⁷² Up until 2011, the German unions lost 40% of their membership and 60% of their financial resources since the reunification.⁷³ However, in parallel to the eroding membership base, German unions also experienced a loss in institutional power since the 1990s. Against this background of decreasing institutional power, membership orientation has become increasingly important for German unions.

Recently, German unions, including ver.di, have started to adopt “organizing” strategies to combat membership losses. Rehder sees the adaptation of organizing strategies by German unions as an example for the relatively rare cases of explicit organizational learning.⁷⁴ While there have been some organizing campaigns as early as the 1990s, ver.di started to actively adapt organizing principles from U.S.-American unions during the 2000s.⁷⁵ However, organizing approaches, which are based on principles of grassroots democracy, participation and the formation of countervailing

70. See Carola M. Frege, *Gewerkschaftsreformen in den USA. Eine kritische Analyse des „Organisierungsmodells“* [Trade Union Reforms in the USA: A Critical Analysis of the “Organizing Model”], 7 INDUSTRIELLE BEZIEHUNGEN [INDUS. REL.] 260 (2000) (Ger.).

71. Britta Rehder, *Vom Korporatismus zur Kampagne? Organizing als Strategie der gewerkschaftlichen Erneuerung* [From Corporatism to the Campaign? Organizing a Strategy of Union Renewal], in HANDBUCH GEWERKSCHAFTEN IN DEUTSCHLAND [UNIONS IN GERMANY HANDBOOK] 241, 252 (Wolfgang Schroeder ed., 2014) (Ger.).

72. *Id.* at 253.

73. *Id.*

74. Britta Rehder, *Revitalisierung der Gewerkschaften? Die Grundlagen amerikanischer Organisierungserfolge und ihre Übertragbarkeit auf deutsche Verhältnisse* [Revitalization of Unions? The Foundations of American Organizing Successes and Their Transferability to the German Situation], 18 BERLINER JOURNAL FÜR SOZIOLOGIE [BERLIN J. SOC.] 432, 434 (2008) (Ger.).

75. Heiner Dribbusch, *Organizing in der Fläche: Die ver.di/SEIU Kampagne im Hamburger Bewachungsgewerbe* [Organizing in the Sectoral Area: The ver.di/SEIU Campaign in Hamburg Bewachungsgewerbe], WSI-MITTEILUNGEN [WSI-RELEASES], Jan. 2008, at 18, 18 (Ger.).

power vis-à-vis employers,⁷⁶ run contrary to central elements of identity formation in the German trade union culture, like the principles of collective representation and social partnership.⁷⁷ The German unions face the difficulty that a conflictual strategy in one area could endanger the still existing corporatist/social partnership arrangements in other areas.⁷⁸

However, some unionists point out that some of the elements that are implemented today as part of the U.S.-American organizing model have actually been part of the repertoire of German unions before but have been “unlearned” to some extent.⁷⁹ In the case of ver.di, representatives of the union point out that lay officials or union members were already very much involved in ver.di’s policy making due to their function in collective bargaining commissions and in boards of the ver.di divisions and levels before “organizing” gained in importance for ver.di.⁸⁰ What is new is the more systematic approach to include members in the process of collective bargaining and to raise membership levels rather than taking an increase for granted.⁸¹

Ver.di has also conducted two comparably well-funded organizing projects in the hospital sector. These campaigns met some problems, e.g., insufficient research about the hospitals in question before the start of the campaigns and little knowledge of external organizers about industrial relations at the organizational level. One major problem was also poor coordination between the local organizers and (parts of) ver.di’s central administration, which posed obstacles to the work of the organizers. Thus, the campaigns brought only limited and largely unsustainable successes.

76. Rehder, *supra* note 71.

77. Jürgen Prott, *Organizing als riskante gewerkschaftliche Erneuerungsstrategie [Organizing as a Risk Trade Union Renewal Strategy]*, in *ORGANISIEREN AM KONFLIKT: TARIFAUSEINANDERSETZUNGEN UND MITGLIEDERENTWICKLUNG IM DIENSTLEISTUNGSSEKTOR [ORGANIZE THE CONFLICT: COLLECTIVE DISPUTES AND MEMBERSHIP DEVELOPMENT IN THE SERVICES SECTOR]* 235, 253 (Andrea Kocsis, Gabriele Sterkel & Jörg Wiedemuth eds., 2013).

78. Rehder, *supra* note 71, at 256.

79. Ulrich Wohland, *Kampagnen, Organizing und mitgliederorientierte Tarifpolitik [Campaigns, Organizing and Members-Oriented Wage Policy: Concepts and Practice]*, in *ORGANISIEREN AM KONFLIKT: TARIFAUSEINANDERSETZUNGEN UND MITGLIEDERENTWICKLUNG IM DIENSTLEISTUNGSSEKTOR [ORGANIZE THE CONFLICT: COLLECTIVE DISPUTES AND MEMBERSHIP DEVELOPMENT IN THE SERVICES SECTOR]* 65, 66 (Andrea Kocsis, Gabriele Sterkel & Jörg Wiedemuth eds., 2013).

80. See, e.g., Interview 07 with Federal Administration Official, Ver.di (Nov. 19, 2014) (on file with author); interview 05, *supra* note 35.

81. See Jörg Wiedemuth, *Mitgliederorientierte Tarifpolitik und Mitgliedergewinnung: Szenarien entlang einer Tarifrunde [Members-Oriented Wage Policy and Membership Growth: Scenarios Along a Bargaining Round]*, in *ORGANISIEREN AM KONFLIKT: TARIFAUSEINANDERSETZUNGEN UND MITGLIEDERENTWICKLUNG IM DIENSTLEISTUNGSSEKTOR [ORGANIZE THE CONFLICT: COLLECTIVE DISPUTES AND MEMBERSHIP DEVELOPMENT IN THE SERVICES SECTOR]* 277, 280 (Andrea Kocsis, Gabriele Sterkel & Jörg Wiedemuth eds., 2013) (Ger.).

However, institutional resources like the works councils could be strengthened.⁸²

One new concept of ver.di, which might be located between traditional union work and organizing strategies, is the concept of “conditional collective bargaining” (*bedingungsgebundene Tarifarbeit*). It has been developed by ver.di in response to fragmented collective bargaining in the hospital sector and has become a recognized strategy within the union by now.⁸³ “Conditional” means that a certain organizational strength is seen as necessary before the union takes action in a company. If the membership level is too low, organizing efforts have to be made before a process of collective bargaining can be started. The union only supports people who are willing to organize themselves and work for their interests, and ver.di will provide information and support to empower the (potential) members.⁸⁴

A key principle of conditional collective bargaining is to find out (e.g., via polls) what the real concerns of the employees are in a given workplace.⁸⁵ Union members are actively involved in drawing up demands, and ballots on results of collective bargaining are held. This close inclusion of employees and members in the process of collective bargaining is not intended to weaken existing actors like works councils and collective bargaining commissions but to reconnect them with the people they are representing.⁸⁶ By some, this is seen as a difference between organizing and conditional collective bargaining because the latter is seen as a way to combine the German model of industrial relations (and not questioning it) with more membership participation.⁸⁷ However, not only organizing but also conditional collective bargaining can come into conflict with “traditional” institutions of German industrial relations, like works councils, who might be skeptical toward such approaches.⁸⁸

In applying the concept of conditional collective bargaining, ver.di was able to achieve very high organizational density in some hospitals (e.g., Damp, 80%) and hospital service companies (60%).⁸⁹ The concept is “evaluated” for the area of company collective agreements and ver.di is currently working on a (partial) transfer to areas with sectoral collective

82. See Oliver Nachtwey & Marcel Thiel, *Chancen und Probleme pfadabhängiger Revitalisierung. Gewerkschaftliches Organizing im Krankenhauswesen* [*Opportunities and Problems of Path-Dependent Revitalization: Trade Union Organizing in the Hospital Sector*], 21 INDUSTRIELLE BEZIEHUNGEN [GER. J. INDUS. REL.] 257 (2014) (Ger.).

83. Thomas Haiptner & Steffen Lehndorff, *Decentralisation of Collective Bargaining in Germany: Fragmentation, Coordination and Revitalisation*, 2014 ECONOMIA & LAVORO 45, 61 (2015).

84. Interview 04 with Federal Administrative Official, Ver.di (Oct. 29, 2014) (on file with author).

85. *Id.*

86. Wiedemuth, *supra* note 80, at 296.

87. Interview 05, *supra* note 35.

88. Interview 04, *supra* note 84.

89. Interview 01, *supra* note 51.

agreements. This poses some difficulties, however. The basic conditions set in conditional collective bargaining—high union density and mobilizing capacity—are presently not fulfilled across the board in most areas with a sectoral collective agreement. Applying conditional collective bargaining to areas that are presently covered by sectoral collective agreements would pose the risk of—or even demand—a (further) decentralization of collective bargaining. Certain principles of conditional collective bargaining, like distributing information material to employees or conducting polls to find out which issues are of importance in a workplace, can be transferred to other collective bargaining arenas, however.⁹⁰

It seems to be disputed among unionists how much organizing and conditional collective bargaining have in common or not. Most feel that the two concepts are not incompatible and could complement each other. However, both methods also meet opposition within ver.di because of the change in mentality—away from principles of representation—that is required for the use of these concepts and the implications for the distribution of resources.⁹¹ The implementation of new practices in ver.di is massively hindered by a lack of resources. Possibly, conditional collective bargaining can be more easily implemented into the everyday union practice and might therefore have less need for (but also less trouble to) acquire extra funding. However, both approaches, organizing as well as conditional collective bargaining, are further pursued within ver.di. Elements of both concepts are to be implemented throughout the organization in the context of the organizational development program “Perspektive 2015” with which ver.di is aiming for more member orientation.

Another strategy that ver.di is pursuing in the hospital sector is to increase membership in the church sector. Since the public sector collective agreement has lost its standard setting function, membership strength has to be developed for widely unorganized areas. Despite the difficult situation, because of the special church labor law, there are cases of church-owned hospitals in which ver.di has been able to organize strikes and other activities.

Even though ver.di is concentrating more on winning members, a radical shift away from the logic of influence toward the logic of membership can so far as not be observed. Lobbying strategies and principles of social partnership are not given up. Lobbying is especially important in the area of health and social services, which is very much dependent on regulation by law. However, more “traditional” approaches to policy making can be

90. Interview 05, *supra* note 35.

91. Interviews 04, *supra* note 84; Interview 08 with Federal Administrative Official, Ver.di (Dec. 7, 2014) (on file with author).

combined with elements of more membership orientation, e.g., in campaigns to influence the public opinion.⁹²

B. United Kingdom

Unions affiliated with the national Trades Union Congress (TUC) began to devote more resources to organizing in response to their political exclusion and the collapse of institutional arrangements (e.g., abolition of the principle of “closed shop,” limitation of the right to strike) in the Thatcher years. Continued bargaining decentralization and the declining bargaining power of unions have increased the need for effective workplace organization in order to secure financial resources and influence.⁹³ In the British “single channel” system of employee representation, unions’ organizational strength at the workplace is closely linked to their bargaining power. Against a background of membership decline and the fragmentation of bargaining structures, reliance on workplace activists grew.⁹⁴ Since the 1980s, union organizing became “a highly formalized and specialized set of activities” in the United Kingdom.⁹⁵

The political climate for trade unions changed after the electoral victory of the Labour Party in 1997. An important political reform supportive to organized labor was the introduction of the Employment Relations Act (ERA) in 1999. It established a statutory recognition procedure and created a more benign environment for union recognition and organization than, for instance, in the United States. At the same time, privatization of public services and labor market flexibilization were further enhanced, and the right to strike remained restricted. Furthermore, the Labour Party reduced its financial dependence on unions and the mutually close political relations became looser.⁹⁶

To respond to the constant decline in trade union density, British unions have relied on two methods to reaffirm their organizational strength; they either try to organize the employer through partnership agreements or, in a bottom-up approach, pursue servicing and organizing strategies. Due to the voluntary character of collective bargaining partnership agreements play only a minor role in the United Kingdom.⁹⁷ Servicing is targeted mostly at

92. See, e.g., Interview 07, *supra* note 80.

93. Edmund Heery, John Kelly & Jeremy Waddington, *Union revitalization in Britain*, 9 EUR. J. INDUS. REL. 79, 83 (2003).

94. Edmund Heery et al., *Organizing Unionism Comes to the UK*, 22 EMP. REL. 38, 42 (2000).

95. John Kelly & Carola M. Frege, *Conclusions: Varieties of Unionism*, in VARIETIES OF UNIONISM: STRATEGIES FOR UNION REVITALIZATION IN A GLOBALIZING ECONOMY 181, 184 (Carola M. Frege & John Kelly eds., 2004).

96. Heery et al., *supra* note 94, at 91.

97. See, e.g., *id.* at 90.

professionals, managers, and freelancers by offering training, career development, and job search.⁹⁸ It almost exclusively depends on full-time officers and is thus very resource-intensive.⁹⁹ The organizing approach is much more widespread. It involves campaigns to identify activists and aims at the establishment of a workplace committee. Workplace representatives are encouraged to recruit coworkers more actively.¹⁰⁰ Since the 1990s, British unions increasingly turned toward U.S. organizing models. The TUC established formal structures (i.e., Organizing Academy 1998, Partnership Institute 2001) to promote campaigns carried out by paid union officers, often organizing teams of mostly female, younger, and better educated activists. Following the U.S. mobilization approach, organizing campaigns were built around issues of immediate relevance for workers.¹⁰¹ Although United Kingdom organizers learned a lot from their United States colleagues, they adapted the approach to the British context; at best, there is “a patchy and uneven use of the methods and principles associated with the organizing model” in the United Kingdom.¹⁰² However, in accordance with the strong tradition of workplace unionism in the United Kingdom, unions succeeded in implementing techniques that help to achieve effective workplace organization, as a basis for membership growth.¹⁰³ However, there are several constraints for organizing such as resistance by existing members and activists, the relatively loose and decentralized structure of British unions with branches being relatively independent, as well as mounting inter-union competition resulting from merger activities since the 1990s.

Trade union revitalization through organizing did not halt the long-term trend toward the decline in trade union density. In the multi-sector unions Unison and Unite membership levels among nursing staff, however, remained stable or slightly increased during the last few years.¹⁰⁴ Likewise, membership was increasing in the professional union, RCN.¹⁰⁵ The RCN mainly organizes registered nurses. Some years ago the professional union opened up its organizational domain to nursing students and health care support workers.¹⁰⁶ In general, health care workers employed in smaller clinics where union representation is low or in institutions run by the

98. *Id.* at 81.

99. See Jon Erik Dølvik & Jeremy Waddington, *Organizing Marketized Services: Are Trade Unions Up to the Job?*, 25 ECON. & INDUS. DEM'Y 9 (2004).

100. Heery, Kelly & Waddington, *supra* note 93.

101. *Id.*

102. *Id.* at 42.

103. *Id.* at 50.

104. Interview 10 with National Official, Unit (Oct. 20, 2014) (on file with author); Interview 11, *supra* note 67.

105. See *Work for Us*, *supra* note 69; Interview 12 with National Official, RCN (Nov. 11, 2014) (on file with author).

106. See Interview 09 with National Official, RCN (Oct. 16, 2014) (on file with author).

community (e.g., health visitors, community nursery nurses) are more difficult to organize than nurses working in big hospitals. The organization of workers who were formerly employed in the public sector but were transferred to outsourced enterprises or business units, is perceived as the biggest challenge.¹⁰⁷

The two most important general, multi-sector unions in the health care sector do not systematically pursue differentiated organizing approaches in different sectors. Rather, these unions apply various membership strategies such as community organizing and relational organizing (see below) across different local units, professions, and ethnical groups. For instance, organizing Polish migrants focuses on cooperation with church-related community organizations and aims at the active participation of people in the trade union.¹⁰⁸ In the years following the opening up of the British labor market to workers from central and eastern Europe, British unions reinforced their organizing efforts among this group of workers. For instance, Unison launched a project aimed at the organization of migrant workers in the health and care sectors that was coordinated by a Polish-native activist.¹⁰⁹ Organizing campaigns in health care often center on issues of general interest, such as public austerity, pay, and quality of care, and address workers, patients, and the government.¹¹⁰

As in other sectors, trade unions of the health care sector have learned from their United States counterparts since the 1990s and have continued to exchange practices and cooperate on projects in organizing. British unionists have adapted (parts of) the U.S. organizing model to the specific context of the health care sector in the United Kingdom. Relational organizing is particularly widespread in the health sector. Instead of “militating” against issues, activists contact their fellow workers in a “friendly” way, by a “sort of one-to-one type recruitment.”¹¹¹ As one trade union officer puts it,

the most important thing to say about the Americans and their approach is that we definitely learned some lessons . . . the key fact that comes across all of this, which is fundamental to relational organizing but also to issue-based organizing, is that you want to talk to workers in the workplace. We also believe that one of the biggest learning aspects has been the need for local activists, people who are prepared to actively work for the trade union in the workplace.¹¹²

107. See Interview 10, *supra* note 104; Interview 16 with National Official, Unison (Dec. 19, 2014) (on file with author).

108. See Interview 10, *supra* note 104; Interview 17, *supra* note 67.

109. See BIS, MIGRANT WORKERS PARTICIPATION PROJECT: UNISON CASE STUDY (2010), https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/32161/10-1099-migrant-workers-participation-unison.pdf; Interview 17, *supra* note 67.

110. See Interview 10, *supra* note 104; Interview 11, *supra* note 67.

111. See Interview 10, *supra* note 104.

112. See Interview 16, *supra* note 107.

Membership-based strategies pursued by general unions in the health care sector focus on organizing and campaigning while professional unions such as the RCN mainly adopt a servicing approach. The RCN does carry out active recruitment only to a very limited extent (e.g., among nursing students) but attracts members mainly via their “marketing” department by support in education and training and skill formation.¹¹³ Organizing initiatives in the health care sector are usually not hampered by inter-union competition, which is low in health care in comparison with other sectors. Representatives of all large unions state that union cooperation is well established within the corporatist system of labor relations in the NHS. Recently, in times of public austerity, union cooperation even increased in order to counter the effects of state policies aiming to reduce public expenditure and investment and the reorganization of the NHS.¹¹⁴

Membership mobilization for industrial action is usually very low in health care as nurses are not prone to strikes due to their professional ethos and their aversion to neglecting their patients. Instead, health care workers adopt subtler forms of protest such as “work to rules.”¹¹⁵ Open conflicts are reported mostly in outsourced, non-patient-related services such as laboratories and among certain professional groups such as health care scientists.¹¹⁶ The recent round of pay setting in the NHS that took place against the background of public austerity was remarkably conflictual, however. After years of wage restraint in the public sector that was unilaterally enforced by the government since the onset of the European fiscal and debt crisis, the government continued this policy in the recent bargaining round in 2014. In response, a number of trade unions (including UNISON, Unite, and GMB) initiated demonstrations and industrial action in the health care sector. Industrial action was also supported—although not actively—by the RCN.¹¹⁷ In the autumn of 2014, a number of hourly strikes and work-to-rule took place.¹¹⁸ While the RNC did not participate in industrial action, another professional union, the Royal College of Midwives, for the first time actively participated in the nationwide strike.

VI. DISCUSSION AND CONCLUSIONS

Most of the existing literature on industrial relations and trade union revitalization tends to emphasize the national level in determining the

113. See Interview 13 with National Official, RCN (Nov. 11, 2014) (on file with author).

114. Interviews 10, *supra* note 104; Interview 14 with National Official, Unit (Nov. 12, 2014) (on file with author).

115. Interview 14, *supra* note 114.

116. Interview 15 with National Official, Unit (Nov. 12, 2014) (on file with author).

117. Interview 12, *supra* note 105.

118. Interview 15, *supra* note 116.

behavior of labor representatives over alternative spatial units of analysis. Trade unions are, therefore, expected to react to internal and external challenges in distinct ways that have been historically shaped by national trajectories. A more recent strand of trade union literature perceives labor transnationalism and solidarity as necessary responses to the European politics of liberalization and the global processes of financialization.¹¹⁹ As labor, product, and financial markets expand from national toward transnational, regional, and global levels, the former seems to appear less appropriate as a point of trade union action than the latter.

There is no doubt that national differences remain a distinctive feature of industrial relations and that, at the same time, national industrial relations institutions and practices have partly lost their formative influence on trade union behavior. Some industrial relations scholars therefore suggest to focus on the sector level as the main unit of analysis.¹²⁰ Others found the level of the (transnational) corporation an appropriate starting point for industrial relations research.¹²¹ Within European studies, a number of scholars take up a multi-level-governance perspective to better understand the complexity of different and new industrial relations actors and practices within the variable institutional geometry of the European Union.¹²² However, to our knowledge there exists no consistent theoretical framework so far that is able to guide a systematic analysis of trade union behavior and its causes and consequences at different spatial and social scales.

By a comparison of the stability and change of trade union membership policies in the hospital sectors of the United Kingdom and Germany, we aim to demonstrate that trade union behavior cannot be understood by focusing on a single spatial unit. While trade unions in the British hospital sector appear to follow nationally-established practices of membership recruitment and organizing despite their comparatively high levels of institutional resources, German trade unions have been found to deviate from firmly entrenched practices and even invented new, “hybrid” forms of policies that include both, existing social partnership and organizing models. How can these social phenomena be explained?

119. Mark Anner et al., *The Industrial Determinants of Transnational Solidarity: Global Interunion Politics in Three Sectors*, 12 EUR. J. INDUS. REL. 7 (2006); Greer & Hauptmeier, *supra* note 2.

120. Barbara Bechler, Bernd Brandl & Guglielmo Meardi, *Sectors or Countries?: Typologies and Level of Analysis in Comparative Industrial Relations*, 18 EUR. J. INDUS. REL. 185 (2012).

121. Pernicka, *supra* note 13.

122. Maarten Keune & Paul Marginson, *Transnational Industrial Relations as Multi-Level Governance: Interdependencies in European Social Dialogue*, 51 BRIT. J. INDUS. REL. 473 (2013).

Table 3
Institutional Contexts of Membership Policies in the Hospital Sector

	United Kingdom	Germany
National industrial relations institutions and practices	Liberal / pluralist model: Decentralized and uncoordinated bargaining in almost all sectors of the economy except major parts of the public sector	Coordinated / corporatist model: Coordinated collective bargaining in core industry sectors, erosion of bargaining structures and practices in (private) service sector
Institutions in health care at national and transnational scale	Beveridge model: Health system tax-financed; high public esteem of NHS guaranteeing universal access to health services and publicly run hospitals; Recently, health care sector subject to (transnational European norms of) public austerity	Bismarck model: Health system financed to largest part by social security contributions (as part of labor costs); devaluation of public ownership and control of hospitals since reunification and spread of privatization; predominance of market logic
Industrial relations institutions and practices in the hospital sector	Corporatist model of IR in NHS Employers and employees have an influence on pay and they collectively bargain over working conditions	Fragmentation and erosion of corporatist IR and sector-wide collective bargaining agreements
Membership practices and policies in the hospital sector	Membership logic guides the behavior of trade unions towards their constituencies as associational strength is a precondition for influencing sector-wide pay and working conditions	Logic of influence has been partly replaced by 'hybrid forms' of orientations and membership related practices. 'Conditional collective bargaining' aims at tying collective bargaining to a certain membership level in a given company

A dynamic, multi-scalar perspective regards actors' perceptions, attitudes and (strategic) behavior as simultaneously embedded in different, though interwoven, spatial scales with particular power relations and institutional logics being prevalent. In the British case, the role of power relationships is crucial in historical struggles to defend public sector institutions against attacks of the Thatcher administration. A reorganization of pay setting in the public sector was sought among other measures by the creation of "independent" pay review bodies, the control of public expenditure, and the encouragement of local management reform. However, the reforms in the public health sector did not result in the decentralization of pay setting. Managers were not able (or willing) to pursue cost-saving

reforms by using local bargaining. Further, the government's double role as reformer and employer resulted in inconsistent policies, and the support for decentralized bargaining—while at the same time maintaining a national system of pay review—can be seen as rather rhetorical.¹²³ Although trade unions in the public sector experienced a considerable loss in membership, professional groups such as teachers, nurses, and doctors “challenged the government's market-style reforms and ensured that they were implemented in modified forms.”¹²⁴ Nurses (as well as other professions such as doctors and teachers) share high professional aspirations and are employed in areas of public services with a high political profile (e.g., high expectations of voters, quality of services) and growing demand.¹²⁵ Pay review bodies have contributed to the resilience of national systems of pay determination. Thus, a logic of coordination between employers' and employees' associations as well as state actors in wage setting and bargaining over working conditions became to be dominating in the hospital sector while in national industrial relations wages and working conditions are largely determined by decentralized bargaining or individual contracts (market logic).

Although PRBs constitute a source of institutional power for trade unions, the governments' influence on wage setting remains high. In the liberal model of capitalism, relationships between labor and state actors are fragile and sometimes even adversarial, in particular in the public sector that is subject to austerity reforms. Trade unions in health care, therefore, have to rely on their associational power to mobilize their members against cost-cutting reforms. At the same time, organizing and other membership-oriented practices are perceived as highly relevant in order to exert power vis-à-vis employers and the state and to maintain legitimacy among members. Norms and practices to recruit and organize new members are strongly established among British unionists and guide their behavior at all scales. Therefore, unions' organizing efforts in health care do not significantly differ from those applied in other sectors and are an integral part of their membership-oriented strategies.

In the case of Germany, one can observe a fragmentation of industrial relations and an erosion of collective bargaining coverage in many parts of the German economy and in the hospital sector in particular. The widespread privatization processes in the German hospital sector, as an indicator for the increasing domination of the market logic, and the accompanying erosion of sector-wide collective bargaining have forced the unions to focus on a

123. Stephen Bach & David Winchester, *Opting Out of Pay Devolution? The Prospects for Local Pay Bargaining in UK Public Services*, 32 BRIT. J. INDUS. REL. 263, 279 (1994).

124. Bach, Givan & Forth, *supra* note 56, at 359.

125. Robert F. Elliott & Keith Duffus, *What Has Been Happening to Pay in the Public-Service Sector of the British Economy? Developments Over the Period 1970–1992*, 34 BRIT. J. INDUS. REL. 51 (1996).

different scale of action: the company level instead of the sector level. The reorientation of union action enhanced the development of new strategies to strengthen or restore the power of the union. In addition to organizing campaigns inspired by the American model, ver.di has developed so-called “conditional collective bargaining” in the hospital sector. This strategy has been successfully applied to various hospitals. Elements of the strategy are also being transferred to sector-level collective bargaining. However, one of the main elements of the strategy—tying bargaining to a certain membership level—cannot be easily transferred to the sector level because it is not realistic to reach sufficiently high membership levels in all establishments covered by a sector-wide agreement. Further, where they are still intact, sector-wide collective agreements and bargaining arrangements endow the union with institutional power resources that might be jeopardized by an exclusive focus on associational power. While trade unions in Germany were too weak to defend sector-wide collective bargaining in the hospital sector against state and employer strategies, they are still able to shape industrial relations at the company level and establish new power resources. This institutional work at the company scale is also—in the long run—aimed at re-establishing a sector-wide collective agreement in the German health and social sector. The development of “conditional collective bargaining” is an example of how power relations at different scales can shape the actors’ strategies and how actors themselves can engage in institutional work and the construction of practices at different spatial scales.

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