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Innovations in Conflict Management

Research Papers

Research Paper 11

**Arbitration and Organizational Change in the Health
Services Executive**

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Introduction

Arbitration is a conflict management process which involves disputes being submitted to a neutral arbitrator or arbitration panel. Normally, parties involved in the dispute present evidence and arguments and then the arbitrator/s reach a decision on how the dispute should be settled. Usually this decision is binding on the parties, but occasionally arbitration decisions are non-binding. To avoid costly legal battles, arbitration is frequently used in the commercial world to resolve disputes arising from business contracts or from the supply and exchange of goods and services. Sometimes it is used to produce fast and fair divorce settlements. Many countries also use it in the industrial relations arena to avoid an unresolved dispute between management and trade unions descending into industrial conflict. Arbitrating industrial disputes can take a variety of forms, but almost everywhere the aim is to secure industrial relations stability. In 2011, a form of arbitration was introduced into public sector collective bargaining in Ireland when the Government and the main trade unions involved in the sector signed the Croke Park Agreement. The purpose of this case study is to assess the impact of the arbitration procedure on collective bargaining and trade union and management relations more generally in the Health Service Executive, a key part of the Irish public sector.

The paper is organized as follows. The first section sets out some of the key principles that shape collective bargaining behaviour and outcomes in organizations. The following section details the organizational context of the HSE and explains some of the challenges it faces in its endeavours to deliver a high quality health care service. The next section describes how the Great Recession, of which Ireland was one of the worst casualties, made these challenges even more complex. The fourth section sets out the key provisions of the Croke Park and Haddington Rd Agreements and explains how these introduced a new form of arbitration into public sector collective bargaining. The penultimate section assesses how this arbitration procedure has influenced collective bargaining behaviour and outcome in the HSE. The concluding section considers whether in light of the evidence produced in the case study the arbitration procedures of the Croke Park and Haddington Rd Agreements should be permanent features of public sector collective bargaining in Ireland.

The Character of Collective Bargaining in Organizations

Unionized organizations normally use collective bargaining processes to align the interests of employers and employees. The extent to which these processes work smoothly depends on two key factors. One is attitudes to collective bargaining, particularly whether employers and

trade unions bring an adversarial or cooperative approach to discussions and negotiations. The other is the relative strength of each side's bargaining power. It is worth examining these two matters in some detail. Consider first the 'attitudinal structuring' of collective bargaining, to use Walton & McKersie's (1965) classic term. When employers and employees are antagonistic to one another, collective bargaining tends to be adversarial in character. For the most part, adversarial collective bargaining involves each side setting bargaining goals that aim to maximize their own interests: little consideration is given to the interests or demands of the other side. As a result, adversarial collective bargaining negotiations normally involve managers and employees going head-to-head in an instrumental, sometimes confrontational, bargaining contest.

In contrast, where employers and employees accept that they may not always see things eye-to-eye yet also recognize that it is in both their interests to reach common positions then cooperative, sometimes called interest-based, collective bargaining is likely to prevail. Interest-based collective bargaining rests on the assumption that management and trade unions can work out their differences through dialogue and mutual adjustment. In other words, collective bargaining negotiations are (mostly) not a 'zero-sum' game where the gains of one party are at the expense of the other party. Collaboration and joint action are the by-words of interest-based negotiations. The key point is that the attitudes of employers and employees to each other can heavily shape the character of the collective bargaining process.

Power is the second factor that has a strong influence on the nature of collective bargaining inside organizations. In a seminal study over half a century ago, Chamberlain (1951) argued that either management or trade unions could wield collective bargaining power, which he viewed as the willingness of one side to agree to the demands of the other side. The willingness (or unwillingness) to agree is considered to depend upon how costly disagreeing will be relative to how costly agreeing will be. The extent to which either management or trade unions exercise power in the collective bargaining process depends on a wide range of factors relating to an organization's internal and external environment – the ability of trade unions to organise in particular sectors, trade union density levels within firms, general economic conditions and the ease with which organisations can relocate operations and so on. Thus a combination of power relations and 'attitudinal structuring' shapes the extent to which collective bargaining processes inside organizations lead to stable and productive management-employee relationships. If trade unions enjoy more power than management and are also motivated by adversarial attitudes, then they will seek – and are likely to secure –

concessions from management. The extent to which this situation can be sustained within one firm is open to doubt, as after a time management is likely to try and exit the relationship by considering strategies such as relocating the business elsewhere. However, the alternative situation of managers possessing more power than trade unions and being committed to forcing through managerial objectives and interests – the situation of managerial unilateralism – may be more sustainable, although not costless. Some argue that with the fall-off in trade union density levels alongside increasing globalization, management has been able to pursue their own agenda even in unionized firms with relative impunity. Managerial unilateralism is likely to be more sustainable as workers may not exit an organization in the numbers necessary to threaten the viability of the strategy. At the same time, where management have and use the upper-hand, the danger is that labour turnover will increase, with engagement from remaining employees being relatively low.

It would be wrong to assume that if either trade union or management enjoy more collective bargaining power than the other side they will adopt an adversarial attitude to employment relations. Either management or trade union may calculate that it is in their long-term interests to foster cooperative management–employee relations even though they have the capability of pushing through their own interests unilaterally. However, cooperative employment relations are probably more likely when both trade unions and management enjoy broadly equal amounts of collective bargaining power. With both sides not having sufficient power to push through their own goals, but enough to safeguard their own interests, then a rational choice for both is to cooperate and make agreements that incorporate their respective interests. But concluding mutual gain agreements is by no means the only outcome when collective bargaining power is in equilibrium. Adversarial collective bargaining attitudes may reign even when collective bargaining power is evenly distributed. In these situations, employment relations inside organizations are likely to become disorderly.

For example, if one or both sides persist in pursuing what Walton, Cutcher-Gershenfeld & McKersie (1994) call ‘forcing strategies’, even though they have not got the capacity to ‘win’, then some form of industrial action is likely to arise and even if this outcome is avoided the organization will almost certainly endure acrimonious employment relations. In this type of organizational environment, low-trust relations prevail between management and trade unions, with collective agreements being difficult to conclude and even harder to implement. In practice, relatively few organizations descend into this level of unruliness. An alternative more likely scenario is that each side recognizes that collective bargaining power

is in equilibrium, but hold back from pursuing their own agenda aggressively. Instead, they usually employ what can be called peaceful co-existence strategies, which involve neither side making excessive demands: confrontation is suspended by each side in recognition of the collective bargaining power of the other. Thus, management does not present radical restructuring proposals and trade unions do not make excessive collective bargaining demands. Employment relations stability is secured by boundaries being placed on adversarial action. Peaceful co-existence strategies of this kind, which effectively mean that managers and trade unions are co-managers of the internal labour market, are likely to be more sustainable in buoyant economic times or when the pressures for organizational adaptation are low. The big upside of these strategies is that an organization escapes the turbulences associated with acrimonious employment relations. The big downside is that organizational change can be heavily constrained, sometimes significantly so.

The Organization of the Health Sector in Ireland

Established in 2004, the Health Service Executive (HSE) has the responsibility of delivering all public health services in Ireland. Previously these services were delivered through 10 regional Health Boards, the Eastern Regional Health Authority and a number of other agencies and organisations. When first set up, the HSE delivered its services through 50 public hospitals and 32 local health offices. Internally, it was divided into four administrative areas, which provided or arranged for the provision of health, community care and personal social services to the people in their areas. Overarching these four regional administrative areas were three national organizational units responsible for providing, developing and coordinating health care policy in the country. In recent years, the organization has gone through significant internal change. There has been a move away from regional administrative areas with the creation of a new Governing Board as well as new national Directorates in the following areas: Acute Hospitals, Primary Care, Social Care, Health and Well Being and Mental Health. However, the regional focus has not been completely lost with the appointment of four Regional Directors of Performance and Integration. More organizational reforms are imminent as the Government seeks to implement its *Future Health* strategy, which envisages amongst other things an overhaul in the way hospitals are financed, a revamping of childcare and mental services, and a big drive to implement a comprehensive community care plan. Currently, the HSE is the largest organization in the country, employing over 100,000 people.

The big organizational changes taking place to the HSE are Ireland's response to the multiple pressures that health care systems are experiencing everywhere. The demand for health care is growing rapidly due to people living longer and increased awareness of the importance of early detection of illnesses such as cancer and diabetes. On the supply-side, huge advances in technological sophistication alongside equally vast strides in the quantity and quality of medical knowledge are making more illnesses and conditions treatable. Delivering state-of-the-art treatment to ever-growing numbers of patients has put the resources of public health services under immense strain: public finance for health simply cannot keep up with the challenges presented by demand and supply-side developments. Compounding the problem is that governments are constrained in providing additional public expenditure by the reluctance of their citizens to fund extra health provision through paying more taxes. Thus, across countries, health care systems face massive budget constraints. In every case, the response to this budget constraint has been a relentless drive to improve productive efficiencies, which commonly has involved bundling together, organizationally, factor inputs like physicians, nurses, hospital beds, and capital in new ways. Thus, massive organizational change to raise the aggregate impact of health care is the order of the day in almost all health care systems.

Although the pace and nature of organizational change in health care systems varies from one country to another, it is invariably multi-dimensional. Some systems have outsourced various services and organizational functions to convert fixed labour expenditures into variable costs as a means of improving efficiency. Contracting-out, performance contracts and internal contracting are examples of measures used to this end. Others have reshaped professional and occupational boundaries so that individual employees possess either a broader or more specialized set of skills to enlarge the range of tasks they can perform. Almost everywhere multidisciplinary health teams have been created composed of different healthcare professionals with specialised skills and expertise to deliver integrated health treatment. In many instances these teams have challenged the autonomy, expertise, values, identities, and ties of individual professionals. A battery of new performance management and measurement systems has been introduced into many systems. On the one hand, performance targets are used in response to patient awareness and assertiveness and public demands for greater accountability. On the other hand, performance appraisals are used in an effort to create organizational cultures that promote continuous improvement.

Introducing large scale organizational restructuring programmes to health care systems is extremely challenging at the best of times, but the task was made much more complex for the

HSE in Ireland with the arrival of the economic crisis. Ireland has been among the worst of all developed economies hit by the Great Recession that started in 2008. The crisis was first financial in character as it involved a number of heavily indebted banks. But the severe squeeze in tax revenues combined with the decision by the Irish Government to use taxpayers' money to rescue these banks from collapse turned the problem into a sovereign debt problem. Bailing out the banks wreaked havoc with the country's public finances, which ended with the Irish Government having to go cap-in-hand to the EU, European Central Bank and the International Monetary Fund, the so-called Troika, to stave off economic collapse. These institutions provided the Government with extra money for it to remain solvent, but it was not done scot-free. Instead, the Troika demanded a major fiscal retrenchment programme that required major cuts to government services. No part of the public services was immune from these cuts. As a result, the HSE not only had to address the challenges peculiar to the health service, but also contribute to the national effort of consolidating domestic public expenditure.

Fiscal retrenchment has badly hit the HSE budget. Between, 2008 and 2013, the HSE budget was reduced by €3.3bn (22%), with a further €721million cut being required during 2013–14. Staff levels have been reduced by over 11,268 whole-time equivalents (WTEs). The drive to cut employment has been relentless. In 2013 the gross reduction of jobs was almost 4,000 WTEs or 4% of the workforce. These large jobs losses were introduced not only to save money, but to allow for the recruitment of an additional 1,025 WTEs in a number of key prioritised areas: the HSE was trying to change the composition of the workforce at the same time as reducing absolute numbers. A number of different methods have been used to cut jobs, including natural turnover (retirements and resignations), voluntary redundancies and other targeted measures sanctioned by Government. Overall, the fiscal crisis has left the HSE smaller and less well-resourced, which has put an even greater emphasis on the organization meeting pressing health care challenges through introducing radical change management programmes. Securing major improvements in organizational efficiency and effectiveness is the only game in town for the HSE.

Negotiating Organizational Change in the Irish Health System

Thus, the organizational context in the HSE for introducing far-reaching change has not been particularly propitious. Going almost overnight from the Celtic Tiger years, when budget constraints were not pressingly tight, to the crisis-ridden years when significant cost savings had to be introduced, amounted to a massive organizational shock for HSE management. In addition, because health care spans a wide range of areas, each throwing up their own idiosyncratic challenges, it is difficult to bring focus to change management by mobilizing internal efforts at reform around a select number of key themes: different parts of the health service would require customized change management programmes. Moreover, negotiating change inside the HSE was inevitably going to be relatively cumbersome as management would be required to interact with different representative groups of employees, nurses, doctors, maintenance staff and so on, all of which involved different priorities and sensitivities and all of whom were heavily unionized. Obviously, the quicker these negotiations can be successfully completed, the faster change management initiatives can be implemented with the active support of staff.

A range of factors can influence the extent to which staff will support change management initiatives, not least amongst them is the organization's industrial relations legacy – the attitudes and power relations between management and employee representatives in the past are likely to shape their interactions in the present. Inside the HSE, the national social partnership regime that existed for more than two decades strongly impinged on how management and employees interacted with each other. First of all, with national social partners determining pay for virtually all HSE employees, collective bargaining processes relating to pay were more or less eviscerated inside the HSE. Effectively for two decades, management and trade unions did not have to engage in fully-fledged pay/productivity bargaining, which potentially can be the source of much acrimony and bitterness. Release from annual rounds of pay bargaining, on paper at least, increased the opportunity for employers and trade unions to engage on issues related to organizational modernization.

During the Celtic Tiger years, HSE management and trade unions jointly operated a workplace partnership arrangement to promote management-employee collaboration and foster organizational change. Walton, Cutcher-Gershenfeld & McKersie (1994) suggest that fostering strategies involve management and employees developing shared understandings about the need for organizational change, agreeing to a series of change management

initiatives that incorporate both their interests and then jointly overseeing the implementation of these initiatives. The workplace partnership arrangement established in the HSE, called the Health Services National Partnership Forum (HSNPF) set out with this endeavour. There was much talk about how the Partnership Forum would release organizational resources, particularly the skills, knowledge and expertise of employees to drive forward organizational change in the HSE. Extensive investment occurred to tutor health sector trade unions and health service management in 'partnership' ways of working. A series of agreements and initiatives were produced by the HSNPF that sought to improve the delivery of health services. Several research studies suggested that a number of these led to some improvements in patient care and hospital performance (Roche & Teague 2014).

However, overall the consensus is that the HSNPF only produced small-scale and isolated cases of organizational change inside the HSE. Certainly the pace of organizational change achieved through workplace partnership was inadequate to allow the HSE to meet satisfactorily the multiple challenges it faced. A variety of explanations can be put forward to explain why workplace partnership in the HSE did not deliver more far-reaching outcomes, but perhaps the most convincing is that neither management nor trade unions were fully committed to the process. On the one hand, management was reluctant to nurture meaningful forms of partnership because they did not want to compromise the principle of the manager's right to manage. On the other hand, trade unions also shied away from partnership ways of working as they wanted to keep intact collective bargaining processes.

In other words, in their actions both management and trade unions caused the HSNPF to remain a largely symbolic organizational arrangement, engaging mostly in matters of little consequence. It is even plausible to argue that both management and unions displayed little interest in developing fostering strategies that required meaningful joint working and high levels of cooperative action. In other words, workplace partnership was a form of organizational scaffolding to hide the continuing preference on both sides for *arm's-length accommodation*. Neither side had much trust in the other. At the same time, both wanted to avoid the brinkmanship and the competitive approach to negotiations associated with adversarial industrial relations. Each side recognized the organizational strength of the other and as a result both were prepared to accept workplace partnership as a peaceful co-existence strategy: each side feigned trust and cooperation when it was necessary and at the same time refrained from launching any initiative that would be strongly opposed by the other as they realized the consequence would be large-scale organizational conflict and disorder. Thus

workplace partnership secured relative industrial relations stability, but the price was modest organizational modernization. The resource rich environment of the health and wider public service during the Irish economic boom further blunted management initiative and fed union resistance to change without and even with compensation.

When the economic crisis arrived in 2008, one of the first casualties was the national regime of social partnership. Soon after, the HSNPF was dissolved, removing the organizational chimera of trust and collaboration from industrial relations in the HSE. At one level, this must have been a mighty relief for HSE management as it was released from using a rather weak organizational process in its endeavours to find large cost savings and efficiency improvements demanded by government. On the other hand, it created a massive organizational quandary – what strategy was it going to employ to restructure the organization? On paper, at least, a number of options were open to HSE management. In their seminal study of strategic negotiations, Walton, Cutcher-Gershenfeld & McKersie (1994) suggest management do not have to rely solely on fostering strategies to obtain organisational change. First of all, it can adopt ‘escape strategies’, which normally arise when management conclude meaningful change is unlikely to happen without radical departure from existing organizational arrangements, particularly employment relations processes. A number of routes are open to management should they decide to try and escape from existing arrangements. One is to close down existing operations, or at least some existing operations, and move to a greenfield site. A related strategy would be to outsource those parts of the organization considered a blockage to change. Another option would be to try and de-recognize trade unions and create a non-union organization with no need to engage in formal collective bargaining and other collective employment relations processes. A milder form of this strategy would be try and marginalize trade unions by creating parallel consultation and representative processes within the organization to deliver change. A third option, used by Ronald Reagan in the infamous air traffic controllers’ dispute, would be to sack any employees on strike and hire permanent replacements.

Limits exist to the extent to which the HSE can pursue escape strategies compared to private sector organizations as the demand for and delivery of health services are relatively immobile, tied to particular areas, which places constraints on a strategy that involves switching parts of the organization to different geographical locations. Nevertheless, some escape strategies are open to HSE management. It could try and emulate the strategies recently enacted by management in the NHS in the UK and seek to either contract-out or

outsource organizational functions, in a fairly radical way, to depart from established collective bargaining structures. Conceivably, HSE management could seek to escape existing industrial relations processes by marginalizing trade unions and related professional bodies through cultivating alternative representative and consultation structures. However, it is difficult to consider this a realistic option as trade unions and professional bodies are woven into the organizational fabric of the HSE, as is the case with other national health systems in Europe. Massive, root-and-branch, organizational change would be required to successfully marginalize trade unions in the HSE. Thus, the scope for the HSE to adopt an escape strategy to realize organizational change has some potential, but it would be highly controversial should HSE management decide to follow aggressively such a strategy.

Cutcher-Gershenfeld & McKersie (1994) also suggest that management can employ forcing strategies to effect change, which involves, as implied in the name, the unilateral imposition of changes to either pay, employment conditions and employee job tasks or sometimes all three. An important distinction is whether management use forcing strategies to realize a limited change management programme, or whether to reconstitute existing relations with trade unions so that the hand of management is strengthened. It is also important to distinguish between managements that simply accept that forcing strategies are likely to cause relations with trade unions and employees generally to deteriorate, but do nothing about it, and managements that seek to minimize the negative consequences of forcing strategies through introducing some compensating initiatives. The ability of management to pursue forcing strategies depends on two crucial variables, prevailing economic conditions and an assessment of the internal bargaining power of management. Forcing strategies are more likely to succeed, in the sense of not triggering industrial action by unions, in depressed economic times when concessions and changes to pay and employment conditions are essential for organizational survival. They are also likely to succeed should management conclude that it had enough power to push through organizational change. But management that seeks to pursue forcing strategies over the longer term runs the risk of producing a disaffected workforce, hardly the organizational foundations for high performance.

Thus, different options uneasily allied to largely inertial adversarial postures were open to HSE management in seeking to move beyond fostering strategies to address the twin challenges of adjusting the organization to the economic crisis and of improving the quality of health care delivery. It could introduce some type of escape strategies, but on paper the options open in this area appeared limited. As a result, employing some form of forcing

strategy to obtain the required level of organizational adjustment seemed to be the only realistic alternative. But enacting a forcing strategy was likely to be risky, not least because trade unions and employee representative groups still had considerable organizational power even in the context of an acute economic downturn. Thus, the strength of a forcing strategy, in the sense of how tough management should be in demanding change, and whether any ameliorative policies should be introduced to cushion the demands for organizational restructuring, became tricky strategic calculations. HSE management was in the throes of pondering its strategic moves when it was thrown something of a lifeline in the form of the Croke Park Agreement 2010.

The Croke Park Agreement 2010 and Binding Arbitration

In 2010, the Government, various public sector trade unions and professional associations concluded a four-year centralized Public Service Agreement. The deal, which was designed and facilitated by the LRC, became known as the Croke Park Agreement, as the negotiations for the agreement occurred at Croke Park, Ireland's premier sports stadium. At the centre of the Agreement was a commitment by public service unions to deliver a raft of operational savings in return for Government agreeing to introduce no further public sector pay reductions (other than those applied in 2009 and 2010) and no compulsory redundancies (as long as public servants were flexible about redeployment). The Agreement also contained Action Plans that identified where efficiencies and savings could be made for specific parts of the public sector. The following were key components of the Action Plan for the health service:

- Redeployment of staff
- Extended working day
- Integration of primary, community and acute care systems
- Multi-disciplinary working and intra-professional governance
- Cost containment through partnership
- Continuous improvement of cost & quality through evidence-based performance measurement
- *Strategic Engagement and Innovation* initiative – to provide the context for national level and local level engagement between unions, management and staff, for rebuilding trust, and dealing with the issues.

In an effort to copper-fasten the commitments made by the respective parties, the Agreement set down a series of provisions for the speedy resolution of disputes, using the State's existing dispute resolution machinery (LRC, Labour Court, and the Civil Service's Conciliation and Arbitration Schemes). These provisions emphasise the importance of seeking to resolve disagreements promptly by setting out clear timelines for the dispute resolution process. Specifically, section 1.24 of the Agreement provides that:

Where the parties involved cannot reach agreement in discussions on any matter under the terms of this agreement within 6 weeks, or another timeframe set by the Implementation Body to reflect the circumstances or nature of the particular matter, the matter will be referred by either side to the LRC and if necessary to the Labour Court.... The outcome from the industrial relations or arbitration process will be final. Such determination(s) will be made within 4 weeks, or another timeframe set by the Implementation Body to reflect the circumstances or nature of the particular matter.

Effectively, the Croke Park Agreement introduced a third-party compulsory arbitration system into change programmes for the public sector. These arbitration procedures were automatically included in the Haddington Road Agreement that came into effect in 2013 when the Croke Park Agreement came to an end. It is significant that these dispute resolution procedures remained the same even though the Haddington Road Agreement is made up of a series of bilateral agreements between the government and individual public service unions whereas the Croke Park Agreement was a single collective agreement. This suggests that Government viewed the procedures as hugely important to realizing its public sector modernization programmes.

Arbitration is a conflict management process in which disputes are submitted to a neutral arbitrator or arbitration panel. Normally, each party involved in the dispute first sets out its case in writing, followed by a hearing at which the two sides present their evidence and arguments in person to an arbitrator or group of arbitrators. After reflection, the arbitrator/s reaches and communicates a decision on how the dispute should be settled. Usually this decision is binding on the parties, although arbitration can also be non-binding. It goes without saying that the role of the arbitrator is to be impartial, objective and fair. Binding arbitration has been used mostly in the commercial sector in Ireland, but less so in industrial

relations disputes. It is usually the Labour Court that practises arbitration in the industrial relations field, mostly by making non-binding recommendations. However, there are cases, although these are isolated, where firms have built an arbitration procedure into their internal conflict management arrangements.

Compulsory or binding arbitration has its supporters and critics. Supporters of arbitration view it as a fair and effective way to resolve disputes. It is regarded as providing a resolution to disputes that could become prolonged and protracted. In addition, in some circumstances it prevents strikes and other forms of industrial action that could potentially be costly to the parties and even to the wider public. On this positive view, the Croke Park (and subsequently Haddington Road) Agreement, introducing a form of compulsory arbitration into public service collective bargaining, can be seen as a pretty significant innovation in the conduct of industrial relations inside the HSE. With arbitration grafted on as an integral feature of collective bargaining procedures, outcomes to negotiations inside the HSE are likely to be less dependent on the power resources or attitudes of HSE management and trade unions/employees groups. If, for example, management seeks to use their power resources to demand unreasonable forms of organizational change or trade unions seek to use their power resources to block or hold up change, a head-to-head clash of the parties can be avoided by the matter being referred to arbitration. At this stage, the merits of the respective positions adopted by the two parties – and not the relative organizational power of the two sides – become the overriding consideration as the Labour Court will be interested above all in reviewing the case dispassionately.

However, the use of arbitration to resolve collective bargaining disputes is not uniformly viewed in a benign light. One well known criticism is that arbitration may have a ‘chilling’ effect on the negotiations process between collective bargaining parties. In particular, employers and trade unions might view an arbitrator or arbitral panel not as neutral experts who objectively mull over the evidence, but as pragmatic problem-solvers who reach a binding resolution to a dispute by ‘splitting-the-difference’ between the demands of the conflicting parties. If employers and trade unions consider a ‘splitting-the-difference’ mentality is in operation then they are likely to inflate their initial collective bargaining target points – what they would like to achieve – so that the final decision of the arbitrator is close to their reservation point – the point below which they do not want to go. On this view, arbitration could actually aggravate distributive or adversarial collective bargaining. Another well-established criticism is that an unintended consequence of using arbitration is that

employers and trade unions become increasingly dependent on it to conclude collective agreements – the so-called ‘narcotic effect’: people become less able or inclined to conclude collective agreements voluntarily. Thus, while arbitration may bring benefits in the short-term by resolving disputes, there are potential negative spillover effects from its use in the longer term.

Arbitrating HSE Disputes

The HR team at the HSE viewed the Croke Park and Haddington Rd Agreements as both an obligation and opportunity. On the one hand, the Agreements obliged the team to reduce employment numbers and increase organizational performance so that the organization could contribute to the national public sector entrenchment effort. On the other hand, the Agreements presented the HR team with the opportunity to speed up the rate of organizational change that it considered to be too slow for too long. For these two motives, the HR team initiated a concerted and comprehensive drive to reorganize work practices in all parts of the HSE. The purpose of this drive was to revise established working time rosters, skill-mixes and staffing levels to increase productivity. In addition, it sought to increase the use of redeployment, revise overtime schedules and develop new sick-leave arrangements to improve cost effectiveness inside the organization. A further part of the drive was to reconfigure existing services so as to achieve the maximum utilisation of contracted hours.

Case Study One: Medical Laboratory Scientists Case Study

HSE management was the first part of the public sector to test the robustness of the Croke Park Agreement by proposing a radical cost saving and reform plan for its medical laboratories. The plan started when an externally commissioned review concluded that a number of inefficiencies and limitations existed to the way laboratory medicine services were organised inside the HSE. As a result, it recommended the implementation of a new co-ordinated system. In the wake of this review, the HSE established a Laboratory Modernisation Process to progress significant reform of its laboratory medicine service, which consisted of 46 laboratories, employing 3,000 staff and with an annual operating budget of €328 million.

Part of the reform agenda involved combining in more effective ways ‘cold labs’, ‘hot labs’ and ‘point-of-care’ testing to improve the quality and turnaround time of medical test results. Management realised that these reforms would entail changing existing work practices in Laboratories. Prior to the Croke Park Agreement, medical scientists working in Labs received a ‘sessional’ payment of €62.88 for work between 5pm and midnight. In addition, they received a €25 fee per test between midnight and 8am. One estimate suggested that a combination of overtime, allowances and fees allowed some staff to earn approximately

€30,000 on top of average salaries of €50,000.

In an effort to save about € million annually, HSE management put forward a set of proposals to restructure overtime and payment for work outside 9.00am–5.00pm. At the centre of these proposals, was a plan to introduce extended working day arrangements for all medical laboratory staff alongside a new payment structure for out-of-hours working. In particular, the reform plan sought to introduce a rostering work system from 8am–8.00pm, Monday–Friday, and to significantly reduce the pay bill for out-of-hours working.

In August 2010, discussions commenced with trade unions on the changes required to work practices, including the implementation of extended working arrangements, and changes to payment systems for out-of-hours working. Discussions were difficult enough, with trade unions demanding that issues, mostly related to process rather than substance, be referred to the central Health Sector Implementation Body, which would determine whether the dispute was covered by the terms of the Croke Park Agreement. After these issues were resolved, an intense round of negotiations was held between management and unions under the auspices of the Labour Relations Commission, which ended in agreement on part of the proposals.

In particular, unions and management agreed to the introduction of an extended working day for staff in the laboratory services from 8.00am to 8.00pm over a five-day week, with the potential introduction of a seven-day week in some locations, based on service need and following local consultation. Importantly, the LRC guided negotiations failed to reach agreement on three issues regarding pay and loss of earnings:

- out-of-hours payment in respect of working midnight to 8.00am Monday to Friday;
- rate of payment for being on standby off-site;
- compensation for loss of earnings and phasing of compensation.

As a result, these three matters were referred to the Labour Court for arbitration, in accordance with the wider Public Service Agreement. After hearing the evidence from the two parties, the Labour Court reached a determination that contained elements of what both parties sought. A new pay structure for out-of-hours working was established, with the main components as follows:

- In future, scientists would receive an overtime rate of time and a sixth between 5pm and 8pm – a lower rate than previously.
- The ‘fee per item’ system would be abolished and replaced with an hourly overtime rate of €47.50.
- Over a 12-month period, staff would receive a compensatory lump sum worth one and a half times their actual loss of annual earnings.
- The first half of this one-off lump sum would be paid 12 months after the new working arrangements become operational – to allow actual losses to be established – with the remaining half paid six months later.

These new payment arrangements fell short of the reforms sought by HSE management. Nevertheless, one estimate was that their introduction would lead to staff on average experiencing a €20,000 fall in earnings, a fairly hefty sum. Both sides, although reluctantly it

needs adding, accepted the Labour Court decision. The HSE estimates that overall the reform package led to annual savings of €8.5 million.

Sources: Authors' Interviews and *IRN*

By any yardstick, this was a hefty catalogue of change management initiatives, which would probably have caused organizational chaos if it had been proposed during the partnership era of the early 2000s – trade unions would have greeted such a programme of reform as akin to a declaration of industrial relations war and would have responded accordingly. But this time round health sector trade unions found themselves in a very different place. If they adopted a purely oppositional stance to the HR team organizational drive then they ran the risk of contravening the Croke Park and Haddington Road Agreements, which involved the trade unions committing to public sector modernization in return for the Government not introducing compulsory redundancies and maintaining existing pay levels. As a result, the majority of trade unions elected to adopt a pragmatic approach to the HR's initiative to revise radically working practices. At one level, this involved almost ceremonial public denunciation of proposed cutbacks as a threat to the health and well-being of the population. At another level, it involved adopting hard negotiating stances on specific organizational change management proposals in order to defend as best they could the interests of their members.

The level of organizational change activity that has taken place since 2010 has been frenetic in nearly all parts of the HSE. Most of the change management initiatives have been introduced after local negotiations between trade unions and staff associations and service managers with the support of the centralized HR function. Few of these local negotiations have ended in impasse or deadlock, although at times they could have been concluded more speedily. As an example of the change management initiatives that have been agreed and introduced, consider the case of the redeployment of 90 staff across the Cavan/Monaghan Hospital group. A centralized appointments department was established for the group, which led to 50 staff being redeployed. In addition, reform of the Outpatients Department led to 40 staff being redeployed across the two sites, which in turned allowed further reform to be introduced: at the end of these changes senior HSE management were confident that the hospital group continued to deliver the same level of service even though a 25 per cent reduction had occurred in staff levels. Similar changes to working time and practices have been introduced locally to different parts of the HSE in all areas of the country.

Cumulatively, this has resulted in the HSE undergoing significant organizational change in recent years. As a senior HSE HR executive put it:

I have been in the IR business for quite a long time and in the last number of years, in my view, health has delivered more change with huge staff cooperation, with significant involvement and with the associations representing staff.

Case Study Two: Night Payments for Non-Consultant Hospital Doctors

This dispute concerns a claim made by the Irish Medical Organization (IMO), the representative body for Non-Consultant Hospital Doctors, for junior doctors to be paid an extra 25 per cent for working after midnight. The dispute was bound up with a wider problem relating to the working hours of junior doctors. For several years, the HSE and the IMO had been at loggerheads about the working hours of junior doctors, which the IMO claimed were ‘dangerously long’. This dispute was ratcheted up during the summer of 2013, when the IMO announced it was to ballot members on industrial action. In the vote, junior doctors gave their consent for industrial action and a one-day, high-profile, strike occurred in October of that year.

Anxious that subsequent planned days of industrial action be averted, the LRC summoned the parties to its offices with a view to negotiating an agreement. After lengthy and difficult talks, an agreement was reached in November. The deal committed the HSE to ensuring that no doctor would work a single shift longer than 24 hours and to be fully compliant with the 48-hour working week rule of the *European Working Time Directive* by the end of 2014. However, the negotiations failed to secure agreement on all points, most crucially on night payments for junior doctors.

This matter had been gaining a head-of-steam over the preceding six months. HSE management had been introducing new work rosters and work patterns in an effort to reduce the long working hours of junior doctors. One change was the introduction of a night-duty-based system that involved junior doctors working between 8pm and 8am. As part of the negotiations at the LRC to settle the working hours dispute, the IMO made a claim for junior doctors to be paid a premium rate of time and a quarter for working after midnight. Its rationale for doing so was that the majority of health workers who worked after midnight received this premium rate. The HSE management refused point-blank to cede to this demand, arguing that the organization faced ‘huge financial pressures’ and that it was required to make savings of €1bn in its budget for 2014.

Neither side would give any quarter in the negotiations as both sides were convinced of the merits of their position – the chief IMO negotiator referred to its demand as an ‘open-and-shut case’. This impasse had the potential of derailing the entire negotiations if either side adopted the old negotiating mantra that nothing is agreed, until everything is agreed. But under the guidance of LRC staff, both sides took a pragmatic approach, agreeing to detach this matter from other negotiating topics on which agreement had been achieved and to refer the matter to the Labour Court under the terms of the Haddington Rd Agreement.

Within a month both parties were presenting their respective cases at the Labour Court. The IMO made three key arguments: (1) junior doctors are being asked to move to a night-duty-based system with a view to reducing their working hours which are currently illegal under the European Working Time Directive; (2) As this is an existing pay rate and standard across the public sector the IMO claim cannot be described as a cost increasing claim;(3) With regard to any cost increasing arguments, the change in roster should allow a net reduction in hours which would therefore reduce the individual employee's salary and should reduce the cost to the HSE.

In reply, HSE management presented three counter-arguments: (1) The claim for payment of a premium rate of time and a quarter is clearly cost-increasing and thus is prohibited under the provisions of the Haddington Rd Agreement; (2) The health services are facing huge financial pressures; (3) Junior doctors will continue to access overtime earnings post-full compliance with the *European Working Time Directive*.

After considering both arguments, the Labour Court came down on the side of the IMO, stating that the HSE management 'was not in a position to provide the financial estimates on which it based (its) opinion. Accordingly, the Court is not in a position to decide that the claim is cost-increasing and thereby prohibited under the terms of the Haddington Road Agreement.'

Sources: Authors' Interviews and *IRN*

For the most part, trade unions and staff associations have negotiated hard for their members, but have seldom adopted positions that would have blocked or slowed down organizational reform. This stance has been fully recognized by the senior management at the HSE: the words of a senior HR executive reflect the sentiment of this group:

Staff associations have been hugely involved and not enough credit or acknowledgement is being given. An awful lot of union officials have played a significant role in delivering the change. Obviously it's a challenge because you are trying to make people do major change which everybody is resistant to but the health service has been relatively dispute-free for a number of years, since 2010. A lot has taken place and I think that that to me has been fundamental in getting us to where we are.

Case Study Three: Changing Work Practices in the Ambulance Service

The core mission of the National Ambulance Service is to provide a clinically appropriate and timely pre-hospital care and transportation service. During the 2000s, senior management of the service increasingly arrived at the view that far-reaching organizational changes were required to improve the performance of the service. A host of challenges were identified as in need of attention to make the service more effective and cost efficient: emergency ambulance services to acute hospital and primary care provision required better integration, ambulance control facilities required rationalization, new technology had to be adopted more systematically and work practices needed overhauling as a matter of urgency. The arrival of the economic crisis only amplified the need for organizational change.

Thus, at the end of 2010, management produced An Action Plan for Change for the Ambulance Service, containing a host of organizational change proposals, including the following:

- the reduction of command and control centres from 10 to 2
- the introduction of new (and separate) work rosters for advanced Paramedics and Paramedics, thereby allowing a more effective deployment of specialized skills
- elimination of a series of restrictive work practices, including revised sick leave cover arrangements, elimination of work practices around overtime hours worked beyond roster arrangements and resource utilisation practices which prevented Ambulance Control Centres from utilising resources to maximum effect
- the introduction of new grading structures to facilitate the creation of new provisions such as Intermediate Care Services that provide transport for patients between hospitals and other medical facilities, which in turn releases emergency ambulances for alternative use
- reduction and reorganization of on-call working, particularly aimed at eliminating of overtime

By any standard, this was a hefty catalogue of organizational change proposals. The level of change envisioned for the service had not occurred over the previous two decades, yet the Action Plan sought the implementation of all the initiatives within the space of a year, by the end of 2011.

Trade unions and staff representatives balked when presented with the proposals for change. Their unified response was that management was demanding too many changes too quickly. Because trade unions were so firm in their opposition to the Action Plan, virtually no progress was made on any of the initiatives during 2011. Thus, the hoped for quick implementation of the initiatives did not materialize, but senior management probably realized this was likely to be the case.

But management did not back paddle on the Action Plan, remaining as firmly committed to the implementation of the proposals as the trade unions were in their opposition to them. At the start of 2012, negotiations were intensified in an effort to obtain an internal agreement of the Plan. But, like previous discussions, these talks bore no fruit. As a result, the matter was referred to the Labour Relations Commission under the provisions of the Croke Park Agreement in the hope that an agreement could be brokered with third-party assistance. At the LRC, the conciliation service was able to broker an agreement on a number of matters, but not on others. This was no surprise to the parties as neither really anticipated that a

complete agreement would be concluded at the LRC as the gulf between the two sides was too large: trade unions were in no mood to compromise as they thought management was being too aggressive in the changes they wanted to implement and management was frustrated with the trade unions for not recognizing that the economic crisis was demanding unprecedented levels of change: the negotiations had descended into the classical bargaining stalemate.

But the LRC conciliation team performed the important role of deflating some of the strong positions held on both sides by first refining and making clearer some of the issues still in contention and then by referring the matter to the Labour Court in a 'calm' manner. The LRC conciliation team wrote a confidential note to the Labour Court so that it would be sensitive to the key issues at stake. When the matter arrived at the Court, it was treated with great adroitness, but after hearing the evidence from both parties, it decided on the following, which mostly related to work practices:

- Removal of overtime to cover short-term replacements, which allowed the Ambulance Service to reduce the 'on call' scheduling of staff.
- Changes to long-distance journey payments so that only time spent completing journey should be payable.
- Establishing overnight stops as standard practice, by making 'return to base' following a transfer of a patient to Dublin the default position.
- Eliminating overtime before and after start times.
- Requiring trade unions and management to conduct local discussions to establish rosters that reflect a standard 39-hour week averaged over the duration covered by the roster. The purpose was to reduce overtime built into rosters.

Clearly, the Labour Court decision fell almost totally in favour of the management position. In making this decision, the Court paved the way for a level of organizational change that is hard to envisage being permitted by a collective bargaining agreement. Ambulance service management lost no time in availing of the opportunity presented by the Court decision as it implemented most of the sanctioned changes within a four-month period and in the process made cost savings estimated at €2m.

Sources: Authors' Interviews and *IRN*

Despite a significant level of agreed change being implemented during a relatively short period of time, there have been occasions when internal agreement has proved elusive on particular change management proposals, thus requiring these matters to be forwarded to the arbitration processes of the Croke Park and Haddington Rd Agreements. Since 2010, the Labour Court has dealt with about 30 cases from the HSE that related to the implementation of both agreements. Some of these cases related to change management proposals on which internal discussions between trade unions or staff associations and management had reached an impasse, but the majority related to situations where trade unions objected to specific aspects of a plan to implement an agreed change management programme. The three boxes above set out mini-case studies of the use of the arbitration procedure set out in the Croke

Park and Haddington Road Agreements to secure a resolution to a disputed change management initiative. It might be useful to provide a quick review of the cases.

The first mini-case concerns the organization of working time in Medical Laboratories. After investigating the matter, the HSE concluded that its Medical Labs were inefficient and costly to operate. The proposals it produced to create a more cost-effective service would have led to significant reductions in overtime pay rates for medical scientists and technicians. Unsurprisingly, these employees, through their unions, strongly opposed the proposals. Internal collective bargaining negotiations could not resolve the dispute and as a result it went to the Labour Court for arbitration. The Labour Court's decision broadly favoured HSE management. The second case study concerns a proposed pay rate for night working by junior doctors. The origins of this dispute lie in the complex negotiations that the HSE had embarked upon with the representatives of junior doctors to reorganize the working time of junior doctors that was required to ensure that the HSE was in compliance with an EU Working Time Directive. As part of these negotiations, the IMO, one of the 'trade unions' for junior doctors, proposed that junior doctors be paid a premium rate of time and a quarter for working after midnight. The HSE flatly rejected this proposal, claiming that it would be too expensive to implement. Once again the arbitration procedures of the Croke Park/Haddington Rd Agreements had to be invoked to resolve the dispute. This time the Labour Court came down on the side of the IMO. The third case study concerns the reorganization of working time and the payment rates for overtime working in the ambulance service. The HSE had proposed a battery of radical organizational changes which it argued were necessary to modernize what it regarded as an almost antiquated service. The unions representing the employees of the ambulance service strongly resisted the changes. Once again agreement to the dispute could not be reached through normal collective bargaining procedures, which led to the matter being referred to the Labour Court to arbitrate. The Court's decision more or less favoured the position of HSE management.

A number of issues worthy of further comment emerge from these cases. First of all, it is evident that the cases involve pretty significant change management proposals: for example the proposals to modernise the country's medical laboratories outlined in Box 1 were predicated on the introduction of radical changes to working time routines and payment arrangements. In the absence of arbitration, it is almost certain that these proposals would have been the subject of protracted negotiations, which in all likelihood would have ended without a clear-cut agreement. Thus, it is fairly safe to conclude that arbitration by

introducing non-negotiable timelines has expedited the resolution of contentious proposals. Secondly, the mini-case studies suggest that the Labour Court – the arbitrator – has acted in an independent manner, with arbitration decisions not going fully in favour trade unions or management in every case. Whereas the Labour Court decision in relation to the ambulance service case study outlined in Box 3 went mostly in favour of HSE management, the reverse occurred in the case related to night payments for junior doctors outlined in Box 2 where the Labour Court decision sided with the trade union position. In the medical laboratories case, the Labour Court decision embodied a compromise by setting out new payment arrangements that fell short of the change being sought by management yet left laboratory scientists significantly worse off.

It is difficult to reach a definitive view based on these three case studies, but the indications are that the Labour Court is adopting a ‘problem-solving’ rather than a ‘split-the-difference’ approach to arbitration. The Court places considerable emphasis – as witnessed in the junior doctors case-study – on the parties presenting evidence and well considered reasons for proposing or resisting organizational change. It appears unswayed by either side evoking general principles in support of their case. Overall, the tenor of the judgements made by the Labour Court suggest that it is accepting of the need for a faster pace of organizational change in the HSE, but at the same time careful that employees do not lose out excessively as a result of change management initiatives.

Senior management at the HSE suggest that the arbitration process has not only led to quicker decision-making on organizational change proposals, but has also resulted in managers being more thorough in developing modernization initiatives. In the past, it was stated that HSE may have been overly concerned with the power aspects of negotiating organizational change, trying to anticipate the reaction of particular trade union representatives to proposals and working out a collective bargaining strategy accordingly. With the introduction of arbitration, greater emphasis is now placed on management developing a case for reform, built on the use of appropriate data, the identification of well-considered reasons for change and an assessment of why the proposed changes are the most viable. Senior management establish review panels to assess the merits or otherwise of any proposed change management programmes. The extent to which this approach has diffused uniformly across such a diverse organization as the HSE is an open question: after all, the Labour Court took HSE management to task for not producing financial estimates in support of their case in the junior doctors pay dispute. Nevertheless, senior management in the organization appear determined

to move away from power-based collective bargaining behaviour towards the broad principles of interest-based collective bargaining as these are more aligned with the arbitration processes of the Croke Park/Haddington Rd Agreements.

The trade unions have adopted a different approach to arbitration. Publically, they have denounced the fiscal retrenchment of the public sector as morally disreputable as it places the burden of adjustment disproportionately on nurses, doctors, etc. who played no role in causing the original financial crisis. In practice, however, they have not adopted overtly oppositional stances to public sector modernization, and at times almost implicitly complying with a ‘sharing the pain’ mentality that was prevalent in the country to secure a return to national economic stability. For sure, they have bargained hard on particular change management proposals yet have more or less acquiesced when Labour Court decisions have not gone their way. On the whole, trade unions have adopted a twofold approach to arbitration being grafted onto public sector collective bargaining. On the one hand, they have used the arbitration process as a third-level opportunity structure – what the French call *le troisième guichet* – to challenge particular elements of management’s organizational change plans. On the other hand, they view the arbitration procedure as a *fait accompli* – something they have to go along with in the interest of protecting their members’ jobs and pay. At the same time, there is little indication of the Croke Park/Haddington Agreements inducing a rethink on the part of trade unions about how they approach collective bargaining matters.

Conclusions

In their assessment of the impact of the Croke Park and Haddington Rd Agreements, a senior HSE HR executive made the following comment:

I actually think that Croke Park 1 changed the dynamic significantly. I think there is a complete undervaluation of the industrial relations climate that we have all been operating under. I think that the two huge deliverables in Croke Park have been the industrial relations environment in the first instance and, secondly, the time bound processes at local, at third party and ultimately at the Labour Court level. I think for health they would be fundamental in delivering change. I have been in the IR business a long time and in the last number of years, in my view, health has delivered more change with huge staff cooperation.

Viewing arbitration as a ‘game-changer’ is largely corroborated by the analysis presented in this case study. Our assessment is that the dispute resolution procedures of the Croke Park and Haddington Road Agreements have had a disruptive impact on the power-based collective bargaining system that previously existed in either an overt or covert form inside the HSE. This disruption has not occurred in any aggressive manner, but as a result of the LRC and Labour Court working in a highly professional manner. These public dispute resolution bodies have operated in a highly complementary manner, first trying to secure an agreement between parties through conciliation and then if this failed by arbitration. Disrupting the power-based collective bargaining system inside the HSE had a decisive impact on the ‘hold-up’ problem it had produced inside the organization. Economists refer to a ‘hold-up’ problem as the situation where two parties may be able to work more efficiently by cooperating, but refrain from doing so due to concerns that they may either give the other party increased bargaining power or weaken their own bargaining power. The introduction of arbitration meant that this ‘hold-up’ problem could be effectively by-passed. No longer could trade unions completely block an organizational change proposal: all they could do was refuse to reach an agreement on the matter, which simply brought the arbitration process into play, thereby ensuring that a definitive resolution to the problem would be reached within a prescribed timetable. At the same time, arbitration did not give management the licence to put forward organizational change proposals willy-nilly. Change management proposals that were not well reasoned and based on convincing evidence ran the high risk of being rejected by the arbitrator. Thus, arbitration changed the dynamics of collective bargaining inside the HSE. Instead of power relations between HSE management and trade unions being paramount, the merits of their respective arguments and evidence in support or against a particular proposal were the decisive factors.

One cannot say for certain whether this shift in collective bargaining dynamics is temporary or permanent. The Irish economy, although still precarious, is slowly but surely edging back from the abyss. As economic times get brighter, trade unions may become more reluctant to sign up to agreements like Croke Park and Haddington Road so that they have greater manoeuvrability in collective bargaining negotiations to oppose proposals they find objectionable. If that were to happen then the momentum behind public sector modernization may slow appreciably. Thus, the best way to avoid a return to the previous collective bargaining regime of peaceful co-existence combined with inertia would be to ensure that present arbitration arrangements continue to exist in some form or other. So far the arbitration

process appears not to have a distorting effect on collective bargaining in the HSE by encouraging the parties to inflate their original position or by making them overly dependent on the Labour Court. The relative novelty of the process alongside prevailing economic conditions may to some extent explain why arbitration has been operating so benignly. It would be naïve to believe that this state of affairs will endure in the future. Because it is not a silver bullet, fault lines of one form or another may begin to creep into the arbitration process – this is the experience from its use elsewhere. Thus, while there is a strong case for making arbitration more or less a permanent feature of the collective bargaining system in the HSE, more needs to be done to ensure that collective bargaining continues to function smoothly.

In particular, more needs to be done in the broad area of ‘attitudinal structuring.’ A strong sense emerges from interviews conducted that while the dispute resolution procedures of the Croke Park and Haddington Road Agreements may have placed a straightjacket on the power interactions between management and trade unions, it has had a modest impact on the attitudes both sides bring to the bargaining table; both sides continue to display a distributive bargaining mentality and are cautious in their dealings with each other. More needs to be done to reframe attitudes to collective bargaining, and employment relations more generally, inside the HSE. This could be decried by the parties as a disguised call for the reintroduction of some form of workplace partnership inside organizations: that experiment is done and gone and there appears no appetite from any constituency for it to be resuscitated. At the same time, there seems to be a need for a new initiative around the theme of workplace cooperation and collaboration, if the momentum for change built up during the recession is to be sustained in better, brighter times.

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