



Shop Floor Power: Opportunity and Collectivism in Nurses' Collective Resignations¹

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ABSTRACT

This historical and comparative study attends to the phenomenon of collective resignation by registered nurses in the Swedish health services, with the aim of exploring the existence and utilization of shop floor power. The study uses two kinds of data: incidences of collective resignation since the 1980s are explored using newspaper data; second, two cases of collective resignation are comparatively explored using interview data. First is analyzed how contemporary opportunities to take this form of worker action arose. Then is analyzed how differences between the two cases shed further light on opportunity structures in different contexts of nursing, and on nurses' ability to organize the resignation threat as a collective act. The study clarifies the existence of nurses' shop floor power as it relates to opportunity structures, while also pointing to the significance of the extent of collectivism when nurses challenge employers by threatening this kind of industrial action.

KEYWORDS

Collective resignation / collectivism / labor conflict / nursing / opportunity structure / shop floor power

Background: shop floor power, neoliberalism, and public workers

In a seminal exploration of global and historical trajectories of labor unrest, Beverly Silver (2003: 123) observed that conflict has been on a long-term rise in service industries, which can be contrasted to the prolonged decline in strike activity in manufacturing in advanced economies (cf. Bordogna & Cella, 2002; Gall, 2013, 2015). The effects of this growing significance of services were difficult to assess, according to Silver, because of the heterogeneity of services. Certain service workers, in aviation for instance, will be able to seriously disrupt interdependent and international business activities through traditional strikes. However, major service industries like education and health care generally do not produce commodities and such workers therefore have little 'structural' or workplace bargaining power. On the other hand, Silver noted, they may compensate for this using 'associational' forms of power (in the guise of strong union organizations and broad, cross-class alliances). However, in the context of contemporary conflicts in Swedish health care (Granberg, 2016), these instructive remarks, which probably reflect the opinion of many labor scholars, do not apply.

Because, in what is nowadays clearly the predominant form of labor conflict in Swedish health services – registered nurses' 'collective resignations' – workers make little use of associational forms of power. Indeed, this local and informal mode of conflict usually

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does not extend beyond the individual workplace; it does not usually seek to mobilize the general public, nor does it rely on resources provided by the nurses' union [unions are not legally permitted to support workers taking this kind of action (Bengtsson, 2006)]. As this analysis will illustrate, the collective resignation, as a form of labor conflict, emerges in the context of health care restructuring (Hood, 1995; Rankin & Campbell, 2009) along what might be called 'neoliberal' lines. Importantly, these restructuring processes involve the introduction of purchaser-provider schemes and inter- and intra-organizational monetary transfers related health care specialization (in addition to outright privatization). In so many words, this constitutes a more or less thorough process of commodification, as against the de-commodification associated with the ascent of the welfare state. In the context of Swedish industrial relations, this commodification expands nurses structural, or 'shop floor' power, in that nurses become capable of inflicting financial losses on employers if they withdraw their labor power. However, as this article suggests, this shop floor power remains latent unless nurses collectivize the threat to resign.

The aim of the present study is to analyze the existence and utilization of shop floor power in nurses' collective resignations. What are the sources of nurses' structural, or shop floor, power? Moreover, how do nurses utilize these sources through collective action? The first finding emerging from this analysis is that certain groups of registered nurses have considerable shop floor power, due to commodification, labor scarcity, and bargaining devolution. Second, comparative case analysis shows important differences in nurses' strategies when utilizing these sources of power in collective action, making for quite different outcomes. Data used in this article consist of two case studies and a study of newspaper reports (Granberg, 2016). The theoretical concepts used in the analyses are those of 'opportunity structure' and 'collectivism'.

By way of introduction, the collective resignation is not a despondent act. In collective resignations, nurses *vow to resign*, but they do not generally intend to quit their jobs. Like the calling of a strike, this puts pressure on employers to accede to the demands nurses forward together with the threat to resign. Certainly, nurses *risk* losing their jobs and might have to find work elsewhere; the collective resignation is a kind of brinkmanship that certain workers who are in high demand and hard to replace are particularly well positioned to play. The nature and context of collective resignations will be further explained in the next section. Then follows a discussion of scholarship on recent patterns of labor conflict in advanced economies, and a discussion of the concepts of opportunity structure and collectivism in the context of analyzing labor conflict; this makes up the third section. The fourth section deals with matters of method. The fifth section presents the analysis and, lastly, the conclusion summarizes the results and considers them in light of the analytical aim and research questions set out in this Background section.

Context: collective resignations and health care restructuring

There is no pinpointing the exact time and place when collective resignations emerge as a mode of collective action. In fact, at the time of the inception of labor movement activity in Sweden, it would seem difficult to separate this mode of action from proper strikes. Absenteeism, deliberate obtuseness, and mass resignations – referred to as 'strikes' or 'stoppages' by Karlbom (1967: 30-1, 130-1, 152, 200) though hardly reminiscent of today's procedural calling of strikes by recognized union organizations – spiked in late

18th and mid-19th century Sweden. While some of these actions involved work stoppages and worker representatives negotiating with management, in some cases, workers collectively resigned, sometimes after having secured alternative employment elsewhere, with the intention of renegeing on this should employers grant sufficient concessions (ibid: 247). Hence, it is clear that ‘mass resignations’ were part of a repertoire of collective action involving a multiplicity of tactics. Later on, in the early 20th century, unions used it against employers who refused to bargain collectively, a strategy outlawed with the institutionalization of industrial conflict in the thirties (Bengtsson, 2006). As we shall see, this led to the collective resignation’s reappearance in informal guise.

There is little reason to believe collective resignations were particularly prevalent in the early postwar decades, which saw relatively low levels of strike activity, in contrast to the turbulent interwar decades (cf. Korpi, 1978). In 1951, however, the nurses’ union, whose membership did not receive the right to strike until 1965, organized a nationwide campaign for collective resignation. The legality of the tactic was disputed, but it never had to be put into effect. The union won significant pay rises in an economy plagued by inflation (Bohm, 1961: 329ff.).

These early incidences of collective resignation appear dissimilar, however, from the current phase. There are two reasons for this: as against the mass resignations intertwined with strike movements in the 18th and 19th centuries, collective resignations now concentrate in the public sector; and as against the pioneering campaign by the nurses’ union in the fifties, today’s collective resignations are workplace-level events organized by the rank and file, independently of unions. The current phase began in earnest during the nineties, that is to say, in tandem with the restructuring of health care, and of welfare services generally, along neoliberal lines. In the nineties, efforts to restructure Swedish health care were made, inspired by New Public Management (NPM) (cf. Hood, 1995). This involved financial reorganization through subcontracting and introduction of purchaser-provider schemes, and took place in a context of economic crisis and fierce drives for cost reduction and productivity increases throughout the public sector (Larsson et al., 2012; Martinussen & Magnussen, 2009). Thus, besides downright privatization, an intraorganizational process of commodification ensued, promoting the devolution, quantification, and transparentization of welfare services, including health care (Blomgren, 2007).

Objections may be raised against labelling this a process of ‘commodification’, because restructuring mostly left services publicly financed (except in cases of outright privatization). Neoliberal reform certainly has a long way to go before health care becomes a commodity sold on open markets. Nevertheless, in terms of the power relation between employers and employees, it is important to stress how reforms tended to introduce a situation similar to that in the private, commodity-producing sector. Importantly, lower-level management in organizational subunits were put in charge of handling ‘their’ local expenses, turning these units into ‘cost centres’ to use the business jargon. Moreover, purchaser-provider schemes in conjunction with health care specialization, and the *inter-county monetary transfers* it brings, meant some hospital revenue now derived from units servicing extra-county patients, rather than local taxes. It will be shown that this puts some health care workers in a position to hurt employers financially, should they withdraw their labor power. This provides these workers with potential shop floor or ‘structural’ power as set out in the beginning of the article.

Turning to the nursing profession, restructuring brought contradictory developments that not only increased registered nurses’ workload but also empowered them. The severe

crisis of the early nineties – and to a lesser extent the milder recessions of the late nineties and in conjunction with the crash of 2008 – took its toll on health care employment (County Councils, 2002; SALAR, 2012). However, reductions overwhelmingly hit groups like assistant nurses, orderlies, and medical secretaries; health care in Sweden ‘professionalized’ as doctors and registered nurses increased relatively (Selberg, 2012: 115–119). In turn, registered nurses assumed some of the tasks of groups who bore the brunt of layoffs. Workload and perceived threats to nurses’ autonomy were behind the nursing union’s critical stance on NPM reform: having first welcomed the integration of nurses into lower-level management, the union swiftly changed its stance in the face of the scale of cutbacks (Blomgren, 2003). Around this time, a shortage of nurses, related to a decline in the status of public professionals like nurses and teachers during the nineties, began to make itself felt, and continues to do so today; with a further drain caused by superior working conditions in neighboring Norway. Further, while registered nurses still mostly work in the public sector, growth of employment agencies increased their mobility. Overall, due to such trends in the nineties and in the first decade of the 21st century, registered nurses on the one hand got scarce and thus strong in terms of labor market position, while on the other hand they were exposed to higher levels of speed up and stress (Selberg, 2012; SWEA, 2014: 429–432). Against this backdrop, the workplace-level drama of conflict unfolds, culminating in the standoff of collective resignation.

The above provides a brief historical account of collective resignations and recent transformations in health care and nursing in Sweden, illustrating the immediate context of this mode of worker action. In a European and Nordic perspective, three features of public sector industrial relations in Sweden should be noted, which help explain the emergence of collective resignations. These are the decentralization of wage bargaining, the relatively restrictive regulation of strikes, and the promotion of specialization and regional divisions of labor in health care.

Compared with other EU countries, Nordic public sector industrial relations were moderately impacted by recent economic crises, in terms of reductions in job levels and changes to public sector employment regulation systems (Bordogna & Bach, 2016; Wesley Hansen & Mailand, 2013). Instead, creeping changes starting with NPM reforms in the late eighties gradually altered the face of the public sector in Nordic countries, shifting the balance of power toward employers, away from unions (Jørgensen & Schulze, 2011; Wesley Hansen & Mailand, 2013). The scale of reform has varied across Nordic countries, however. Looking at public sector collective bargaining, Sweden stands out in having implemented a system where top-level bargaining has to a large extent been replaced by forms of local bargaining (this applies especially to registered nurses whose union has pioneered this trend) (Thörnqvist, 2007; Wesley Hansen & Seip, 2017). Master agreements are still decided nationally, however. This fact, together with the peace obligation in the collective bargaining law, leaves Swedish nurses in a peculiar situation where wages are largely decided locally, whereas the right to take collective action is restricted to the national level. In addition, while membership ballots play an important role in public sector bargaining in a country like Denmark (Scheuer et al., 2016), such ballots were removed in Sweden as unions centralized in the early postwar decades. Lastly, in terms of commodification of public services, it should be noted that health care in Sweden, as in other Nordic countries, has seen increased regionalization and specialization and thus increased monetization of services (cf. Vrangbæk, 2009).

Theory: opportunity and collectivism

The coincidence of 'labor quiescence', that is, the marked decline in strike activity since the eighties, and the revival of popular contestation in connection with the last economic crisis, including in specific kinds of strike activity (Chirino, 2016: 384), appears to have precipitated an increased concern with the *forms* of worker action (cf. Gall, 2015; Kelly, 2015: 729). Furthermore, to the extent that popular fightbacks against crisis-related austerity policies have included strikes, labor scholars have turned their attention to an increase in the incidence of general or 'mass' strikes in the advanced economies, mostly carried out by public workers (Kelly et al., 2013). Thus, the workplace-based strike of the seventies, carried out by workers in manufacturing and the extractive industries, would appear to have been superseded by large, highly profiled, and primarily symbolic, protest strikes by public employees. What is lacking from this picture, painted by contemporary labor scholarship, is any measure of local action on the part of public workers. Indeed, although prone to support union-led mass strikes, the public workers of today would appear to lack the kind of workplace-level activism that characterized labor militancy in the seventies. This would also seem to apply to Nordic scholarship on recent episodes of industrial action. For example, scholars have analyzed large, union-led strikes with a view to their outcomes (Scheuer et al., 2016), and the union-led resignation campaign by Finnish union TEHY in 2007, which mobilized some 12,000 nurses (Henttonen et al., 2013). Therefore, labor scholarship on new workplace-based forms of action is likely to enrich our understanding of contemporary conflict.

The collective resignation as carried out by registered nurses in Sweden is a new form of local labor militancy. In contrast to the union-led strike, it is an emergent and increasingly prevalent form of action in this country. I contend that it reflects the existence and utilization of 'shop floor power'. It reflects the *existence* of shop floor power in the sense that transformations in the organization of health care and the institutional arrangements of public sector industrial relations have empowered nurses by creating the *opportunity* to threaten resignation as an effective means to improve their lot. Furthermore, it reflects the *utilization* of such power in so far as nurses are able to exploit the existence of this opportunity by making the threat to resign a *collective* act; otherwise, resignation would be a mere act of despondency or at best an individualist career strategy. Thus, the manifestation of shop floor power requires both the existence of the opportunity of threatening resignation as an effective lever *and* the collectivization of such threats. For these reasons, in order to explore the rudiments of shop floor power as manifested in nurses' collective resignations, I draw on the concepts of 'opportunity structure' and 'collectivism'.

'Opportunity structure' refers to the features of a power relationship and its wider context that enable and facilitate the taking of collective action as well as increase its efficacy in achieving desired outcomes (Kelly, 1998: 25, 27, 37, 100). For example, in the heydays of labor militancy in manufacturing during the seventies, interrelated production processes empowered blue-collar workers who did not hesitate to use surprise tactics: this was the very foundation of their 'structural' power (Silver, 2003). This opportunity relates to the organization of labor processes and the nature of products, but another important opportunity structure is the industrial relations system and laws regulating collective action. The concept of opportunity structure thus abstracts from subjective processes, such as interest articulation and the practices and strategies of

organizing, to foreground the given, structural, features preexisting mobilization for collective action. However, just these processes are central when analyzing ‘collectivism’ (Kelly, 1998: 39ff.) In particular, the present study attends to how episodes of collective resignation display different organizational patterns and strategies. The latter are conceived as key determinants of whether nurses are able to collectivize the threat to resign. Considering that collective resignation is based on the legal right of *individual* workers to quit their jobs – and considering the individualizing features of the neoliberal milieu where this mode of action thrives (e.g., individual wage setting) – it should be emphasized that workers can be organized on collective as well as individual grounds. That is, activists may call on workers to take action as individuals or as collectivities, reflecting how group interests are articulated in worker struggles (ibid: 6-9). The question of collectivism thus relates to the concept of ‘organization’. In Tilly’s (1978) original formulation, the concept spans both embryonic modes of organization embodied in the labor process and formal and informal, union and nonunion, local and extra-local, modes of organizing proper. In terms of the collective resignation, which is an informal mode of action that implies *ad hoc* organizational forms, a key question of organization is on what basis the decision to threaten the employer with resignation is taken. Is it taken individually or is it somehow collectivized?

In the analysis, I first explore processes relating to opportunity structures. Time-series data will be used to explore which groups of nurses take collective resignation and how bargaining institutions condition their actions. Interview data and case comparison is used here to gauge the impact of commodification, which is difficult to assess on the aggregate level. Together, this will provide an assessment of opportunity structures making collective resignation feasible for nurses. Subsequently, interview data and case comparison is used to analyze organizational patterns and strategies.

Methods: time series and case study analysis

Collective resignation is not an officially recognized form of labor conflict and the Swedish National Mediation Office does not collect data on it, as it does for illegal (wildcat) strikes. Moreover, collective resignations are not illegal unless conducted by a union organization, in which case it would most likely be ruled as an illegal blockade (cf. Bengtsson, 2006) and so become a matter of public record. Hence, the informal, though legal, nature of collective resignation makes it difficult to assess its incidence. While official strike data are not completely reliable, and have been deemed to underrate the extent of conflict (Thörnqvist, 1994: 91), the incidence of collective resignation has not been researched at all.

Official work on strike statistics, as well as influential studies in the field (e.g. Silver, 2003), have searched newspaper reports to construct time series of different forms of collective action. Nowadays, this is even more feasible due to advances in newspaper digitization. Using the Digital News Archive (*Mediearkivet*), two searches were performed whose results are used in the present study. The searches targeted 1) collective resignation in general and 2) collective resignations among registered nurses. The first search was meant to provide a preliminary indication of which categories of workers have used collective resignation. The second, more detailed, search was intended to create a time series that would allow for an analysis of the incidence of nurses’ collective

resignations. The first search involved reading reports with the word ‘mass resignation’ (*massuppsägning*) in the headline and/or opening paragraph. The word ‘mass resignation’, rather than ‘collective resignation’, was used because it is a term favored by newspapers. The second search included a wider set of terms in order to detect as many events as possible and spanned the entirety of article texts: ‘nurses’ (*sjuusköterskor*) was combined with ‘mass resignation’ or ‘protest’ (*protest*) or ‘revolt’ (*uppror*) or ‘resigning’ (*säga upp sig*). *Protest* was used because of its generic quality (it is used to describe very different kinds of contentious behavior). *Uppror* has been used in several recent grassroots political campaigns, including nurses, midwives, and student nurses. Lastly, *säga upp sig* is a common rephrasing of *uppsägning*. Thus, every newspaper report containing ‘nurses’ and at least one of the four latter (truncated) terms, anywhere in the article, were captured in this search.

The first search detected 29 episodes of collective resignation carried out by different categories of workers, whereas the second detected 100 episodes of collective resignation carried out by registered nurses. To be sure, this material will underestimate the real incidence of collective resignation (the first search manifestly does, as it failed to detect most episodes detected by the second). However, regarding the first search, results are only used to show that while registered nurses are especially prone to take collective resignation, the phenomenon is not confined to this worker category. Thus, the first search can illustrate that several groups of public workers use this mode of action. Furthermore, because the latter search yields data that should allow for an analysis of incidence over time, there is an obvious problem: in the years searchable in *Mediearkivet*, from the early eighties up to the present, the number of digitized newspapers increase. A rising incidence might then reflect advances in newspaper digitization, rather than a real proliferation of collective resignations. In order to remove such distortions, a second time series was created, drawing on a constant set of newspapers.¹ This second series is presented along with the first, full archive, series in the analysis below. Despite these precautions, however, results based on these small data sets must be taken as tentative rather than conclusive.

As explained in the previous section, time series analysis will be supplemented with comparative case analysis in order to explore opportunity structures more comprehensively. For instance, newspaper data allow for an analysis of the outcomes of worker action, thus pointing to facts relevant to opportunity structures in the areas of contemporary nursing where collective resignation occurs. These findings are complemented by case study comparisons. Case studies are complementary because while aggregate level analysis allows us to gauge effects of labor scarcity and changes in bargaining institutions, for example, it is not used here to assess effects of commodification, as it is difficult to determine whether the workplaces where collective resignations occur charge other health providers for their services (as well as the scale and significance of this revenue stream). However, making such an assessment is possible using more detailed case studies. Further, in the previous section, I stated that shop floor power is only partly about its existence as a potential, that is, as an opportunity workers have; its manifestation requires the collectivization of threats to resign. Whereas the first aspect of shop floor power can partly be analyzed at the aggregate level, the second aspect requires comparisons of cases displaying different degrees of collectivism.

Hence, two cases of collective resignation are compared with regard to opportunity structures and collectivism. This is a theoretically informed analysis of information

given in interviews with ‘activist’ nurses (informants who described themselves as trying to mobilize the wider collectivity behind the threat to resign), which focuses on facts and events related by informants that are relevant to the two concepts considered here to make up the rudiments of shop floor power. Interviews are thus used as primary sources on how conflict transpired and on some of its determinants. In all, 17 interviews were held, but for the purpose of this study, analysis is restricted to interviews with activist nurses. In contrast to other interviews, which may be analyzed to elucidate different dynamics involved in labor conflict (e.g., ideology, cf. Granberg, 2015), activist interviews contain extensive reflection on the course and efficacy of collective action. Activist nurses are thus taken as expert witnesses, favorably positioned to describe conflict and its immediate determinants. Furthermore, while the first case study employed narrative interviewing and involved a larger set of informants ($n = 12$), the second case study was restricted to nurses who were assumed to speak in a capacity of activists ($n = 5$). However, to illustrate the results of the analysis, it will not be necessary to draw on all activist interviews: two or three per case will suffice. Quotes and block quotes are intended to illustrate findings and, more specifically, are used when informants describe events or facts relevant to opportunity structures and collectivism.

Episodes were sampled for the purposes of constructing and testing theory (cf. Emmel, 2013). That is, the second case was designed to facilitate a comparative evaluation of the hypotheses that opportunity structures and collectivism are key determinants of collective resignations. Hence, it was important that cases differed in their outcomes, as well as regarding opportunity structures and degrees of collectivism. The first episode was something of a half measure: only one-third of the nurses employed at the facility chose to hand in their resignations, and their action only resulted in moderate improvements that fell short of what nurses had demanded. The second case, in contrast, saw the collective resignation come to fruition: almost all registered nurses at the facility vowed to resign and their demands were fully met. I will provide a more detailed description of the how two cases differed below, but first I will note some similarities. The episodes occurred within 2 years of each other, and within the period 2011–2016 (I will not be specific for reasons of anonymity), and both took place at intensive care wards of major hospitals. Both conflicts, according to activists, took place against a background of cut-backs, speed up, stress, and incursions by management on what nurses’ saw as their professional autonomy.

I will call *Case I* the less successful case of collective resignation (where only one-third of the registered nurses threatened to resign and demands were not fully met); and *Case II* the more successful collective resignation (where nearly all registered nurses threatened to resign and demands were fully met). Case I saw nurses demand a large pay raise (4000 *kronor*; considerably more than usually afforded in ordinary rounds of local wage setting). This demand was complex in the sense that activists considered it not just an end in itself that the group should be better paid but also as a means to facilitate recruitment to the ward, which they described as chronically understaffed. The nurses’ demands in Case II were in a sense more straightforward. They sought to prevent a reduction in wages by preserving a local contract about to be scrapped as the hospital introduced a new framework for wage setting, although activists of Case II also recognized such a reduction would mean problems of staffing, and thus more speed up and stress. Hence, while both cases exhibit wage-related demands that were expressly related to working conditions more generally, Case I was a proactive and Case II a defensive action.

Furthermore, the cases illustrate different histories and traditions of struggle. Nurses in Case I did not have prior experience in taking collective resignation. According to activists, there had been times when discontent spiked, when management reorganized the ward or failed to grant satisfactory wage raises (that would reflect the nurses level of experience, training, and education), but no collective action resulted. In contrast, nurses in Case II had taken collective resignation a decade earlier in order to stave off a similar move by management to scrap the local contract. In addition, nurses in Case II worked at a specialized and more commodified intensive care facility; more commodified in the sense that they mostly treated patients from other counties, treatments which thus generated income for the employer. Nurses in Case I did treat extra-county patients, but not to the extent that nurses in Case II did, because while the intensive care ward in Case II had a national obligation to provide treatment, the ward in Case I only had a regional obligation to do so. The contrast reflects different degrees of specialization within the overall framework of Swedish health services.

Analysis: incidence and cases of collective resignation

The four subsections that follow reflect a two-step analysis. The first two subsections deal with matters related to opportunity structures. The first subsection thus attends to incidences of collective resignation and in particular to how changes in public sector collective bargaining and wage setting gave registered nurses institutional opportunities to take this kind of collective action. This analysis is based on data from searches in newspaper archives. Some inferences are made here, which are further interrogated in the subsequent subsection dealing with the results of the comparative case study analysis. This subsection is based on case comparisons that attend to the sources of worker power and how these sources were varyingly present in the two cases. It extends the analysis of opportunity structures by pointing to the importance of commodification. While the first couple of subsections deal with the existence of shop floor power as a potential, the last two subsections are concerned with the utilization of this potential and accordingly focuses on the extent to which nurses in the two cases were able to collectivize the threat to resign. The third subsection thus attends to differences pertaining to organizational patterns in the two episodes of collective resignation, while the fourth inspects the organizational strategies that these patterns reflect.

Opposition: labor scarcity and bargaining devolution

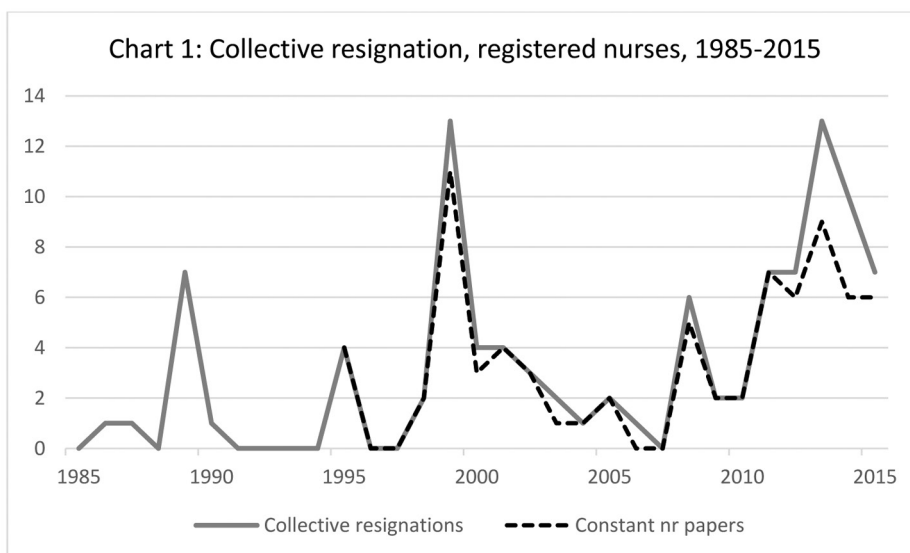
Who carries out collective resignations? It seems it is mostly public employees. The search on 'mass resignation' detected one collective resignation carried out by workers in the private sector (forestry). Police officers, firefighters, medical doctors, and social workers figure among the occupational groups that apply this strategy, but it seems this collective action mainly takes place in health services, and publicly employed registered nurses collectively resign more frequently than any other group.

From the second search, on registered nurses, it is clear theirs are workplace-based actions. In an average case of collective resignation, 17 registered nurses vow to resign. This reflects that mobilization is rarely total: threats to resign are usually made by

a majority, though not all, of the nurses at a workplace. About 70% of the actions occurred in fields that require specialist education (e.g., district nursing, anaesthetics, and intensive care). Specialist nurses are also more likely to succeed when taking collective resignation. It was possible to establish an outcome in 68 of the 100 reported collective resignations by registered nurses; in some 44% of these, nurses chose to take back their resignations after having secured concessions from employers. Overwhelmingly, these ‘successful’ collective actions were carried out by specialists, with nurses in intensive, surgical, and emergency care making up the vast majority.

Thus, it is mainly a *scare* group of public workers in Sweden, registered nurses, who carries out collective resignations and, particularly, specialist registered nurses. This suggests these groups enjoy opportunity structures making collective resignation relatively feasible. Partly, this reflects the scarcity of their labor power. However, the rest of this subsection and the ensuing one suggests this is not the whole story.

Looking at the time-series of collective resignation by registered nurses in Chart 1, it is clear that this collective action has become increasingly prevalent. This conclusion also holds when considering the second time-series, using a constant set of newspapers. The latter diverges from the full-archive series toward the end of the period, probably because digitization advanced rapidly. Nevertheless, it displays the same rising trend, and short-term fluctuations in the two series are obviously correlated.



A trademark of informal labor conflict in Sweden is that it has tended to supplement the formal system of collective bargaining, in the sense that spikes in local wildcats have followed centralized negotiations and the signing of contracts at the national level. This pattern was especially clear in the seventies and eighties (Thörnqvist, 1994: 140). To see whether collective resignations reflect opportunity structures that the institutional framework of collective bargaining in the public sector provides, we should accordingly relate it to bargaining rounds and to changes in the bargaining system.

There is a link between rounds of central collective bargaining by the nurses' union and brief spikes in collective resignation, intersecting a secular trend where collective resignations increase with devolution of bargaining. For example, the first collective resignations coincided with the wage negotiations and the strike of 1986. The eighties saw a gradual shift from centralized bargaining to local and individual forms of bargaining (before, nurses only received differential pay based on age). Hence, central level bargaining became less important as a determinant of wages. The first real spike in collective resignations, in 1989, followed on the central negotiations in 1988 and a general move toward decentralization whereby local bargaining became more important in setting wages for white-collar county workers. The head of the nurses' union stated that collective resignations helped the union secure satisfactory local settlements (*TT*, 18/1-89). Economic crisis in the nineties interrupted the trend toward bargaining devolution as the state intervened in the negotiations of 1991-1993; this would also appear to have dampened collective resignations. A new, though modest, spike took pace during the build-up to the strike of 1995. Grassroot campaigns and local vows to resign *en masse* pressured the union to bargain hard and launch the strike. The resultant contract increased bargaining devolution and is described as a breakthrough for individual bargaining in nursing (cf. Calmfors & Richardson, 2004: 18-20).

The third spike, in the late nineties, similarly coincided with a bargaining round, which resulted in the contract of 2000. In contrast, however, this spike was more pronounced, and registered nurses across the country were clearly aware, given the extensive media coverage, that their colleagues were taking action, making this spike resemble the waves of strikes ignited by high-profile wildcats, such as the strike wave following the miners' strike of 1969-1970. The nurses' union, rather than applaud militancy as it had in the past, condemned it as a potential breach of contract (*Dagens Medicin*, 27/4-99). Thus, while in the eighties the union seemed to encourage collective resignation, it dropped this permissive stance in the nineties. Significantly, while in the late eighties collective resignations followed the close of central negotiations, in the nineties, local action preceded and thus pressured top-level bargaining.

In 2005, when the contract of 2000 expired, there was no renewed surge in collective resignations. However, the bargaining round still marked a watershed. A contract without fixed terms was signed, to be renewed annually, removing guaranteed minimum pay raises for individual nurses, which were now to be settled locally (though, importantly, centrally agreed general pay raises were retained). Discontent with the settlement grew among the rank and file and, in the build-up to the strike of 2008, there was a nationwide resignation campaign: thousands of nurses vowed to quit unless wages were substantially raised; and local negotiations triggered a spike in workplace-based collective resignations. The contract of 2008 also meant a return to centrally guaranteed minimum wages, which, combined with additional raises secured in local negotiations, seem to have dampened collective resignations. As the 3-year contract expired, however, there was a new spike and this time more pronounced, a scenario that was repeated in the following bargaining round of 2013. However, the 2011 contract was the real watershed in that it dropped centrally agreed pay raises altogether, thus placing wage setting entirely in the hands of local parties. Predictably, this has been accompanied by high levels of local conflict in recent years.²

While developments in collective bargaining by themselves do not explain fluctuations in the incidence of collective resignation – fiscal crises and changes in demand for



nurses' labor power probably also affect the latter – the link between bargaining and collective resignation, shown above, is nevertheless a strong indication that collective resignation relates to institutional opportunities arising from the move to a more decentralized bargaining system. As wage setting became a local issue, collective resignations increased. This suggests that collective resignation supplements the formal bargaining system and that it substitutes union-led strikes, much as the wildcats of the seventies did (Thörnqvist, 1994: 140).

Opportunity structures II: commodification

Turning now to the two cases of collective resignation, another opportunity structure linked to this mode of action comes into view: commodification. However, all facts and events activist nurses considered significant in determining the outcome of conflict will be considered.

In the context of capitalist employment relationships (i.e., the sale and purchase of labor power as a commodity), there are two main sources of worker power. First, a particular form of labor power may be scarce, in part because what employers require is skilled, as in experienced and/or educated, labor. Second, the labor process will be more or less vulnerable to disruption and, relatedly, employers will be more or less *financially* vulnerable to disruption (but this presupposes that workers produce goods or services sold as commodities). Employer vulnerability translates into worker opportunity, and changes in this opportunity structure affect the power-balance between workers and employers (Kelly, 1998: 100).

Both cases saw a scare group of registered nurses threaten employers with a withdrawal of labor power, in the form of handing in letters of resignation. Both groups also presented this ultimatum at a particular juncture, increasing the pressure put on employers: in connection with summer scheduling, a notoriously difficult process given the nursing shortage; employers regularly offer provisional bonuses to nurses who agree not to go on vacation during these months. Although in Case I, as against Case II, the intensive care unit was not specialized, this did not make the nurses any easier to replace: they had to handle a greater variety of patients than nurses in Case II who worked in a particular field of intensive care. In this regard, both groups were probably equally hard to replace. Reflecting this strong labor market position, in both cases, several nurses applied for Norwegian licenses and secured new jobs as conflict progressed.

However, looking at the financial vulnerability of employers, the cases differed in important ways. Both wards serviced extra-county patients, thus bringing in additional income to their counties. In Case I, the ward served a number of regional counties, and this allowed the group to put additional pressure on the employer according to an activist:

We serve this entire part of the country, and – of course – we're aware of what that means. When we brought this up with the bosses, they we're clearly concerned [...] I mean we're not so stupid not to have our own impact assessment of what it would mean if all of us left, in terms of the ward's regional responsibility. It's like they think we're isolated at the ward, you know, us and our little patients [laughs], but we know how this world works (Case I)

However, in Case I, activists did not emphasize the financial vulnerability so much as the political and moral hazards involved should the county fail to fulfil its regional obligations. To be sure, the unit and the county stood to lose income, but activists did not stress this (pointing to other forms of financial risk, e.g., training new nurses and paying expensive agency staff). In Case II, in contrast, activists did emphasize the specific financial risk of income loss. The following accounts testify to this:

I'm really surprised they didn't back down earlier. Because the surgery carried out here, which would have ground to a complete halt if we all had left, is a major source of income for the region. I mean, it's not a negligible amount of money – it doesn't just finance our department but a good part of the hospital as a whole (Case II)

The region has a national obligation to serve these patients, so it would've lost lots of money if it weren't able to do this kind of work, if it went to others. So, there's competition here, and that's key to how things played out. They realized, 'my god, we're about to lose a real cash cow here!' I think that was important, when they realized that (Case II)

It is clear from the above that Case II reflects a more advanced stage in the restructuring, specialization, and commodification of health care in Sweden. The county structure is replaced here by a larger region and the intensive care ward serves, not just neighboring counties, but a national market. The activists are aware that the income their labor creates is needed to run other parts of the regional health care system; in their view, this was key to the successful outcome of their collective action. The opportunity structure that consists in the financial vulnerability of employers, who receive a significant portion of income from specialized units providing care services paid by external organizations, thus appears as a determinant of the viability of collective resignation, and thus as a source of nurses' shop floor power.

Collectivism I: organizational patterns

Organization does not preexist collective resignation. Rather, organization is an emergent and mostly ephemeral feature of these collective actions, as it is in wildcat strikes in Sweden, which unions are also forbidden to organize (cf. Granberg, 2012). Therefore, when situations warrant that nurses take collective resignation, the problem of organization instantly presents itself. In light of debates on 'individualism' in contemporary advanced capitalism (Kelly, 1998: 64-65), the most salient problem in collective resignation, where the right to resign formally rests with the individual employee, is how individual and collective modes of decision-making are co-articulated. Case I and II differ markedly here.

First, however, a striking similarity in the description of the background to the two episodes of conflict should be stressed. In the early years of the new millennium, the newspaper searches detected many collective resignations prompted by the cancellation of agreements regulating staffing and scheduling on inconvenient hours, including pay supplements. Since these are local agreements, and since local unions are not allowed to take industrial action, canceling them is a relatively feasible way for management to cut labor costs. This happened in both our cases in the early 2000s, though while in Case I management was able to enforce a considerably less generous scheme, in Case II the

registered nurses threatened to resign and kept the original agreement. Nurses in Case I were thus, some 10 years later, fighting the effects of this alteration; staff had left and a reduced number of experienced nurses were under severe stress. On the other hand, in Case II, nurses were yet again faced with management trying to cancel the staffing and scheduling scheme they had successfully defended some ten years ago.

This background explains the fact that Case I was an essentially proactive move; in the subsequent section, it will be shown how nurses tried to enforce a significant pay rise in order to attract more staff to specialist training programs and to the intensive care ward. In contrast, Case II was a reactive action: yet again, nurses fought off an attempt to cut labor costs by canceling the agreement on inconvenient hours. The fact that the earlier struggle, waged by the nurses in Case II, was broadly similar to the situation they faced 10 years later meant they could draw on this experience.

In general terms, the modes of organizing for collective resignation in the two cases differ in the sense that Case I may be characterized as a *coordination* of individual acts, while Case II saw the *collectivization* of individual acts. Accordingly, in Case I, activists describe how they picked up on signals from colleagues that they were planning or contemplating to leave the ward, mainly because they did not want to put up with poor conditions anymore. Activists then informed management of this: ‘I thought if [management] heard that so many were about to leave they would act quickly’ (Case I). However, management did not act on these warnings, and as time wore on activists received word from an increasing number of nurses that they would resign unless grievances were addressed. ‘We told them to hold on – “let’s bring this up with the bosses [...] and give them a chance to act on this”’ (Case I). Thus, activists coordinated individual acts in order to win concessions, but they did not set up collective forms of decision-making.

In Case II, local negotiations were combined with meetings with all registered nurses at the ward. This provided a forum for joint discussion, and management’s insistence on scrapping the old scheme meant union representatives had to deliver a series of bad news that inflamed sentiments. Because this group of nurses knew they had been able to face down management before, there emerged a spontaneous call for collective resignation:

We had a meeting with a high turnout where we discussed this. ‘Where are we now, what has [management] offered, what are our key demands?’ Then many expressed how they couldn’t see any acceptable resolution. ‘I’m definitely willing to resign over this – is this an option for us?’ It developed quickly. Someone printed out forms and we started to sign. We put up a list on the bulletin board where we noted the resignations we had collected at the meeting. We figured that we needed at least fifty per cent to sign for it to be effective. (Case II)

In the days that followed more colleagues signed, and in the end, the vast majority did. Thus, activists in Case II did not merely coordinate individual acts; the above account illustrates that individual decisions to resign were anchored in collective forms of decision-making. Case II illustrates a more collectivized – and more effective – mode of organization.

Collectivism II: organizational strategies

While different organizational patterns reveal the morphology of collectivism, only by attending to activist strategy and how it affected these different organizational patterns

is the agency involved in collective action foregrounded. This is not a contingent factor that can be safely passed over in a study on the emergence of a form of worker action, such as the collective resignation. Rather, this agency is an expression of cultures of solidarity and struggle (Fantasia, 1988), which may have considerable longevity. The following comparisons show how differences in this regard affected collectivization.

In general, Case I and II display differences with regard to how activists worked to bring about group cohesion. These differences were linked to differences in organizational strategy. Activists in Case I did not attempt to recruit additional colleagues behind the threat to resign because they understood conflict action as something fundamentally individual: ‘everyone had to make up their own minds and we didn’t want to pressure them into anything’ (Case I). While activists in Case II respected that some nurses did not want to resign – indeed, they related how they had to stop some colleagues from castigating this minority – the previous section showed how they organized to make colleagues join collective action. Further, their collectivizing strategy facilitated the articulation of collective interests (Kelly, 1998: 6–9), as will now be exemplified with reference to the use of ‘email lists’ in the two cases.

Because both groups worked shifts, placing coworkers in contact with each other was done through email communication, in addition to face-to-face meetings, which were not always easy to arrange. The email list is thus an important means of internal communication in contemporary collective resignations by registered nurses. Differences in how this means was used may be seen from the quotes below.

I was very busy with the email list [...] People on vacation or parental leave had to be kept in the loop. And I tried to keep everyone up to date with how things progressed and to inform them about their rights (Case I)

The email list allowed us to discuss and decide on the issues that came up. ‘Should we accept this [offer] or should we keep going?’ And people got to have their say (Case II)

Whereas activists in Case I used the email list for one-way communication, activists in Case II used it to facilitate a continuous process of collective decision-making, thus providing a forum for the articulation and reaffirmation of a set of demands and, implicitly, a set of collective interests. Activist nurses in Case II referred to the latter as ‘keeping the group together’.

Efforts to keep the group together also guided a specific approach to the media. Activists in Case II stressed the dangers of a situation where different individuals made a range of unplanned statements. Instead, they insisted, only designated representatives should make previously agreed upon statements. Otherwise, they reasoned, things would inevitably be said that did not reflect everybody’s opinion, which would undermine group cohesion. In contrast, activists in Case I considered talking to the press desirable in and of itself; as an exercise of public workers’ legal right of whistleblowing (*meddelarfrihet*), reflecting their overall outlook on conflict action as fundamentally individual. Thus, they encouraged coworkers to talk to the press: ‘I asked if anyone else wanted to say something [...] I hoped that they would and that if they did others would feel emboldened to follow suit’ (Case I). The result was a series of articles in the local paper that had the effect of polarizing the nursing collectivity (cf. Granberg, 2014).

This strategy was all the more detrimental given problems relating to interest articulation, hampering the mobilization drive in Case I. As explained above, Case I was basically a ‘proactive’ collective action in the sense that activists demanded a pay rise to combat the drain on experienced personal the ward had seen since the cancellation of the local agreement on inconvenient hours in the early 2000s. This meant activists had to endure charges of greed and irresponsibility (Granberg, 2015). Moreover, to counteract the drain on personal, they had to enforce a local pay rise (above that afforded to other intensive care nurses in the vicinity). This affected interest articulation: the localist nature of demands barred the use of some encompassing moral frames (cf. Kelly, 1998: 29) often applied in nurses’ collective actions (e.g., equal pay and gender equality). Instead, activists in Case 1 had to combine particularistic concerns with how work at their specific ward was remunerated with a more general frame that foregrounded how the quality of care would improve with higher pay and more staff. Getting this message across was difficult, and news reports with spontaneous statements by individual nurses from the ward aggravated these problems. In contrast, in Case II, the unified and restrictive media strategy, together with the defensive maneuver of resisting a wage cut, was unproblematically combined with wider moral frames such as fighting austerity politics and defending the rights of patients to quality care services.

Conclusion: the existence and utilization of shop floor power

The conclusions of this analysis are necessarily dual, given the aim to explore the existence and utilization of shop floor power. I argued that shop floor power is on the one hand a mere potential, a structural opportunity to exert power and force concessions from management through collective action. On the other hand, shop floor power becomes manifest, in and through collective resignation, only when activists manage to collectivize the threat to resign.

In order to answer the question ‘What are the sources of nurses’ shop floor power?’ the present study undertook an analysis of opportunity structures. Data on incidences of collective resignation suggest these sources include labor scarcity: it is registered nurses in particularly short supply, the specialists, that are most prone to take collective resignation and that are most likely to carry it out successfully. In addition, the incidence of collective resignation over time suggests this informal mode of action works to supplement the formal bargaining system – spiking in bargaining years – and substitute union-led strikes. Time series analysis also suggests collective resignations become more frequent with devolution of bargaining: local bargaining presents certain groups of nursing specialists with the opportunity to take action to improve their lot. Moreover, case comparison suggests an additional reason, besides scarcity, why it is mostly specialist nurses who take, and succeed when taking, collective resignation. These nurses are often found in specialized hospital units, functioning as ‘cash cows’ of local health care systems by treating extra-county patients for money. Through commodification, efforts to restructure Swedish health care seem to have empowered nurses working in such units, enabling them to wield a ‘structural’ power that has mostly been confined to industrial workers. Importantly, as health care specialization advances, the economic significance of these workplaces grows, along with nurses’ shop-floor power.

In order to answer the question ‘How do nurses utilize these sources of shop floor power?’ an analysis was undertaken of collectivism in the two cases of collective resignation. Case comparison showed that the more successful case of collective resignation (Case II) displayed organizational patterns that involved a higher degree of collectivization than the less successful case. The latter case involved the coordination of individual threats to resign, but activists did not seek to make this threat a product of collective decision-making, as in Case II. Moreover, different organizational patterns were found to reflect different organizational strategies. While activists in Case I tried to accommodate individual attitudes on whether or not to resign and urged individual nurses to voice their own grievances to managers and the press, activists in Case II consistently tried to ‘keep the group together’. That is, in addition to integrating the (by legal necessity) individual decision to resign into collective forms of decision-making, activists in Case II worked to strengthen group cohesion through, for instance, strict media policy. In doing this, they seem to have benefitted from previous experiences in taking collective resignation and from the fact that their prior militancy meant they could wage the essentially defensive struggle of staving off employer efforts to reduce labor costs.

Looking at these findings from a Nordic perspective, three features of Swedish public sector industrial relations and health care organization stand out. Arguably, the concoction of these features explain the salience of collective resignation in this country, as compared with other Nordic countries. In the first place, *restrictive regulations on strike action* have produced a tradition of informal action with considerable longevity. Second, together with relatively pronounced *bargaining decentralization*, this means wages in the public sector are increasingly set in a local context where workers do not have the right to strike. However, and this is the twist, such devolution places the battle over wages at the exact level where a rare existence of shop floor power in public services has evolved, as an effect of the third feature: health care *specialization* and *commodification*.

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Endnotes

- ¹ Because digitization makes a bit of a leap in the late nineties, the second time-series starts in 1995. It is based on nine papers, held constant throughout the period: one news agency (TT), four national newspapers (*Aftonbladet*, *Dagens Nyheter*, *Expressen*, *Svenska Dagbladet*), three local newspapers (*Göteborgs-Posten*, *Helsingborgs Dagblad*, *Västerbottens-Kuriren*), and one trade journal (*Dagens Medicin*)
- ² For this account of recent developments in collective bargaining, I rely on newspaper reports, principally from *Dagens Medicin* and TT.