The health care industry is vital; it touches all of us. It also faces great challenges.\(^1\) Aging populations and new technologies, along with increased expectations, are putting increasing pressures on health care providers to contain costs and seek more efficient and effective methods of managing, while at the same time working on ways to improve the quality of patient care.

In recent years, there have been many health policy developments and initiatives—including, of course, in the United States, where the Affordable Care Act of 2010 was introduced to increase access to health care for most Americans. Although other developed market economies have long had systems of universal health care, they also face cost and quality challenges.

The challenges in this industry include budget cuts and changed funding models, how to improve productivity, the use of outsourcing, greater accountability in terms of implications for the workforce, patients, and other stakeholders.

In a range of countries that are confronted by such challenges, there is growing concern about the social and economic sustainability of health care systems.

It is not easy to make international comparisons of health care arrangements because the contexts vary among countries. The United States has some of the world’s best hospitals and is at the forefront of medical research. However, it also has a high degree of inequality. Among the thirty-four member countries of the Organisation for Economic Co-operation and Development (OECD), on a per-person basis, the United States spends more than double the $3,322 annual average of all OECD countries.

Yet according to some indicators, the United States is not getting value for its money. For instance, the recent report, “Mirror, Mirror on the Wall,”\(^2\) verifies that the U.S. health care system is the most expensive in the world, but comparative analyses consistently show that the United States underperforms relative to other countries on most dimensions of performance. Among the eleven nations discussed in the report—Australia, Canada, France, Germany, the Neth-
erlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States—the United States ranks last (as it did in earlier editions of “Mirror, Mirror”). The United Kingdom ranks first, followed by Switzerland, Sweden, and Australia.

Since 2013, when the data in “Mirror, Mirror” were collected, the United States has made progress in adopting health information technology, as well as implementing reforms under the Affordable Care Act. Continued implementation of that law, focusing on redesigning current delivery systems, could help create more-efficient health care organizations, which would improve the quality of care and reduce costs. Nonetheless, these data prompt us to compare experiences among countries.

This article summarizes presentations at LERA’s 2014 annual meeting about health care in the United States, the United Kingdom, and Australia, and includes comments by two distinguished discussants. We conclude by developing questions for further discussion and research.

United States: Workforce of the Future in Partnership

Dennis Dabney, senior vice president, Labor Relations and Office of Labor Management Partnership for Kaiser Permanente (KP), gave a presentation titled “Navigating the Workforce of the Future in Partnership.”

KP was founded in 1945 with a mission “to provide high-quality, affordable health care services and to improve the health of our members [enrollees] and the communities we serve.” KP’s Value Compass puts the patient at the center of its work (Figure 1).

KP has 175,000 employees, of which more than 48,000 are nurses and 17,000 are physician partners who work in thirty-eight hospitals and at more than 600 medical office buildings and outpatient facilities. KP serves approximately 9.3 million members in eight states and the District of Columbia.

KP is a managed care organization. It has been developing new ways to bring health services to members and their families in their communities. Therefore, its workforce is confronting change. The focus of KP’s innovative mobile and community-based facilities enables KP members to access health care services near their job locations, at “health spots.” The sites are staffed by medical assistants or licensed vocational nurses who provide remote access to a clinician via a monitor.

By using mobile health vans, KP is bringing services to members at locations
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convenient to the communities where people live. This effort requires creativity in terms of providing multiskilled workers who can drive a van and act as a receptionist and cashier—as well as provide routine medical examinations.

Dabney stressed two goals that KP aims to achieve with these clinics: easy access to care and opportunities for new health care jobs. In implementing such services, KP has been creating a comprehensive process to involve the workforce in the development of new services. Having a comprehensive labor–management partnership process in place at KP has enabled labor and management to work together to develop new services and has created novel roles for health care providers.

The challenges in creating the new jobs include jurisdictional issues among several unions because KP is creating new work responsibilities. As a result of the long-standing labor–management partnership process at KP, there has been an effective way to deal with issues between labor unions and management. This Labor Management Partnership (LMP) has helped the process of creating mobile health centers go smoothly.

KP’s labor relations and operational strategy includes considering the workforce implications as it develops new services, as well as fostering involvement of the workforce in designing and implementing new services both in traditional and new community settings. KP’s labor–management partnership with the Coalition of Kaiser Permanente Unions has helped make the transition to new jobs and job responsibilities an effective process instead of one that would face resistance.

Dabney emphasized the importance of retraining and redeploying workers as new services are developed and new technologies are available for patients and staff.

Although KP has not fully implemented its “health spots,” it is making significant progress in designing effective services and being proactive in engaging its frontline staff to prepare for necessary changes in work and making sure training takes place in a timely manner.

**United Kingdom: Integrating Care Services**

Ana Lopes and Stephanie Tailby of the University of the West of England presented a paper on behalf of their team based in Bristol, “Integrating Healthcare and Social Care Service Delivery: A Bottom-Up Evaluation of the Work and Employment Relations Effects in the UK.”

There is a history of proposals for closer links between the National Health Service (NHS) and social care services in the United Kingdom. In the past few years, there has been much discussion about the concept of integrated care in health and social care policy debates.

The interest is paralleled in other market economies, though each has its own trajectory and vocabulary of integrated care debate. The concept of integrated care is slippery. Successive taxonomies have been generated in the effort to interpret, for example, what is being integrated, at which levels or along what planes, to what degree, and with what purpose.

However, the appeal in England has been to try to shift the balance of care away from the acute care (hospital) sector and toward settings closer to home, or in the patient’s home, as being more economical. This has occurred in the context of projected rising demand (an aging population and a changing disease profile). Simultaneously, there have been attempts to improve the quality of patient care by “joining up” the various services and eliminating duplication.

The concept of integrated care has been at the center of health policy debate in the context of reforms of the NHS, which, over three decades, have favored competition, commissioning, and private sector involvement as a way of improving the efficiency and quality of care performance. The most recent initiative, the 2012 Health and Social Care Act, proposed major change for the NHS in the context of public expenditure austerity.

The evidence base for integrated care is limited. The workforce and labor relations implications of “care closer to home” have yet to be subject to systematic scrutiny. But that may be changing, and the United Kingdom’s National Institute for Health Research (2014) envisages that the reconfiguration will be profound.

The paper presented is based on an evaluation study of a health and social care service delivery integration initiative in 2013–2014 in the West of England. A social enterprise (a “spin out” from the NHS) community health provider and local authority social services department, with other local health care providers and within the Clinical Commissioning Group’s aim for “strategic commissioning,” have been establishing integrated locality care teams.

Response nurses work shifts to provide 24/7 urgent patient care to mirror, in effect, the systems of acute hospital care. The proposal was for therapists to align, by participating in weekend shifts, and for generic support workers to move to longer days.

These initiatives were presented in different ways: as the means of achieving the prime objectives of quality patient care and its delivery closer to home and as a response to government prescription that publicly funded health care should operate at full service seven days a week.

Following a discussion of the national policy context and the methodology, Lopes and Tailby drew on interview data to consider the views of health and social...
care staff about integrated care. The researchers did not find much evidence of union voice in the case study.

In addition, they highlighted particular challenges of trying to introduce change in a period of austerity.

This presentation also emphasized the importance of undertaking research relating quality of work life and quality of care.

**Australia: Lean Thinking, Quality Improvement, and Work Intensification?**

The Australian health care system appears to be a hybrid of approaches that are seen in the United States and United Kingdom. As in the United Kingdom, in Australia there has long been universal coverage and publicly funded health care. But to a much larger extent than in the United Kingdom, there is also a substantial private health care sector in Australia.

On behalf of his colleagues, who are all based in Melbourne, Greg Bamber presented the paper, “Lean Thinking and Quality Improvement, Audit Culture and Work Intensification in Nursing in Australia.” He discussed the responses of nurses to the development of ward-level “lean” teams in a big public hospital in Australia. The Lean Ward program was inspired by the apparent success of the Toyota Production System in the car manufacturing industry, which was renamed Lean Thinking.

The Lean Ward program considers the importance of improving patient care and the efficiency of nurses in ward-based quality improvement projects, with the explicit goal of increasing direct care time with patients. While initiated as a top-down process, the program also attempted a bottom-up approach, which involved frontline staff in decision making.

The paper examined the impact of the Lean Ward program in relation to nursing workloads. The highly interdependent nature of nursing work underpinned nurses’ complex relationship with the audit culture associated with process improvement.

The researchers explored key aspects of the experience of nurses with the implementation of “lean” in relation to nursing labor processes, work intensification, professionalization, and nursing values. They found a lack of engagement with the lean projects by lower-level nurses and work intensification for senior nurses associated with implementing the projects. In addition, there were insufficient resources to provide training to maintain a “core lean group,” which ultimately compromised the sustainability of the projects.

A key finding was that nurses identify with the aim to improve patient safety, and some found value in applying Lean Thinking. However, the value is compromised by the increasing intensity of nurses’ work. This situation is a reflection of government-led health reforms that mandate high bed-occupancy rates and maximize patient flow.

High levels of work intensity inhibit the participation of nurses because of the extra work associated with lean projects. Hence, high work intensity can ironically undermine attempts to increase efficiency.

**Discussants: Adrienne Eaton and Tom Kochan**

Adrienne Eaton, from Rutgers University, highlighted parallels in the presentations from Australia, the United Kingdom, and the United States, in spite of the different contexts. The parallels include the challenges involved in releasing health care workers from nonessential chores so that they have more time in which to provide care.

She also cited the challenge for health care employers in “backfilling” jobs while the incumbents are being trained, as well as when staff are needed to assist with implementing process improvement solutions.

Eaton also drew attention to the knowledge and insights about the importance of “relational coordination” being applied in health care. She pointed out that Jody Hoffer Gittell’s work in the health care and other industries might be helpful in providing a conceptual framework when discussing changes in work systems. She also asked whether the difficulties described in making change were a result of poor implementation or a misconceived project.

Thomas Kochan, from MIT, reminded us about the enormous challenges facing this industry in the United States and elsewhere. For example, he pointed out that the technologies often are changing more quickly than the labor–management practices.

On the basis of in-depth research at KP, he applauded the company’s management and unions for negotiating retraining provisions to help affected workers learn the skills they needed for new jobs. It is also appropriate, he said, to reassure staff facing change that their employment is secure. This approach both supports the workers affected and motivates others to continue to foster, rather than resist, productivity-enhancing technologies and related changes.

Kochan also commented on the profound implications of shifting to community-based and home care settings as disruptive organizational change, which results in crossing the traditional health care demarcation lines of the various occupational groups (i.e., scope of practice), as well as union jurisdictions. He suggested that we create forums to

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discuss the nature of shifting jobs and professional issues. In addition, he said we should be proactive in addressing such challenges before they become large problems.

**Some Lessons Learned and Some Research Questions**

We conclude from this symposium that for health care delivery system changes to be effective, it is helpful for labor-management practitioners to have a dialogue with each other and with researchers at the “contemplative” stage—as changes are being considered.

There are too many examples in health care and other sectors where senior managers or technical staff try to impose change unilaterally. In those cases, unfortunately, frontline staff and union representatives are brought into discussions only after decisions have been made. This tends to put labor and management representatives into an adversarial relationship, and it reduces the opportunity for frontline staff to provide input on how to improve arrangements.

Many problems could be avoided if more attention were paid to bringing frontline staff and their union representatives into the process at an earlier stage. We have seen good examples of this approach in other sectors (e.g., car manufacturing).

Such involvement can also improve the quality of decisions because frontline staff are the ones who usually know where many of the barriers are. Those staff have much to contribute to solutions if they are included in joint problem solving. Their involvement is invariably essential in making and sustaining successful changes.

This symposium raises two series of research questions. First, at a micro level:

- What research is needed to better understand how to involve frontline staff?
- What can help in integrating top-down and bottom-up change initiatives?
- How can we best evaluate the resources that are necessary for unit-based and organization-wide changes?
- What are the new roles of professional associations, unions, and their leaders in helping with much-needed transformational activities?
- What encourages managers to work as partners with staff and their representatives?
- What are the most effective logistical arrangements for providing health care in or near a patient’s home?
- What new skills does that workforce need?
- What are the implications for workplace health and safety in terms of these new jobs?

Second, at a macro level:

- What can we learn from other countries and other industries that have already made significant transformative changes?
- Which forms of systemic coordination are most effective?
- Which forms of health care are the most effective from the perspectives of patients, professional and operational staff, funders, and other stakeholders?

The specific case of integrated care in the United Kingdom does not look very positive. A lesson from both the United Kingdom and Australia presentations is the developing syndrome of “reform fatigue,” which follows from many attempts to introduce change into their health care systems and the apparent lack of consistency on the parts of those who try to implement such approaches. A consequence is that there is a tendency for cynicism among staff when faced with another proposed change.

It is interesting that the NHS is trying to learn from innovations at Seattle’s Virginia Mason Hospital. The U.S. health care system has proved difficult to reform—to what extent are the Virginia Mason and KP organizations exceptional cases of “best practice”?

Internationally, there is much potential to learn from each other about improvements in health care delivery and to find better ways to innovate while controlling costs. Symposia such as this one on the important topic of change and innovation in health care are helpful in terms of fostering dialogue about innovative labor and management practices and encouraging further research and practical methods for implementing appropriate changes.

**Notes**


Adrienne Eaton is chair of the Department of Labor Studies and Employment Relations at Rutgers University. She conducts research in union participation in management decision making and the relationship of unions to direct forms of worker participation; negotiation, effectiveness, and outcomes of neutrality and card check agreements; and the impact of unionization of particular groups of workers. She is a member of the editorial boards for Labor Studies Journal and the Journal of Workplace Rights. She is past editor-in-chief of LERA and was a former member of the New Jersey Public Employment Relations Commission. Her work has been published in Industrial and Labor Relations Review, Labor Studies Journal, Advances in Industrial and Labor Relations, and several book chapters. One of her co-authored publications is the book, Healing Together: The Kaiser Permanente Labor–Management Partnership (Cornell/ILR Press, 2009).

Thomas A. Kochan

Thomas Kochan holds the George Maverick Bunker Chair of Management and is a professor of work and employment research and engineering systems and co-director of the MIT Sloan Institute for Work and Employment Research. His work calls attention to the challenges facing working families in meeting their responsibilities at work, at home, and in their communities. His co-authored books include Learning from Saturn (Cornell/ILR Press, 2001). His books also include Restoring the American Dream: A Working Families’ Agenda for America (MIT Press, 2005). He led the formation of LERA’s Employment Policy Research Network, an online think tank. He is a former president of the predecessors of LERA and of the International LERA.
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