

**Draft Report**

**Labor Policy to Support Healthcare Reform**

**Revised 8/7/08**

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## Executive Summary

There is universal agreement that along with expanding access, healthcare reform will need to address quality and cost problems. There is also a growing consensus that addressing these problems requires an engaged, coordinated healthcare workforce, labor-management relations that support engagement and coordination, and tighter systems of accountability. To date, however, no proposal for healthcare reform has included a coherent workforce and labor-management relations strategy or a well developed system for improving performance or holding healthcare organizations accountable for working toward these objectives.

This paper presents an integrated framework and strategy for engaging the healthcare workforce to address the quality and cost components of healthcare reform. The framework is summarized in graphic form in Figure 1. It builds on lessons learned from innovations in workforce engagement and labor-management relations in healthcare and other industries and proposes a set of changes in labor policy needed to support efforts to improve the delivery of healthcare in America.

The reform proposal is built on four principles, the first three which are discussed in this report. The fourth is the subject of a separate report.

***Principle 1:*** *Improving quality and containing costs require an engaged workforce with the knowledge, skills, and capacity to work together in a coordinated fashion.*

*Physicians, managers, supervisors/team leaders, nurses, and other employees need to be empowered and held accountable for reducing medical errors, improving productivity, implementing and using new technologies, and generating and implementing ideas that improve performance and reduce costs.*

***Principle 2:*** *Traditional adversarial union-management relationships do not foster this type of engaged and coordinated healthcare delivery system. However, despite existing legal and institutional obstacles, some alternative partnership-based models have*

*emerged and demonstrated their value in promoting engagement and coordination. These are the exceptions to the norm and are difficult to sustain over time. Thus, labor policy changes are needed to encourage and support labor-management partnerships.*

***Principle 3:*** *Labor law is currently based on adversarial principles that will make it difficult, if not impossible, for this model of healthcare reform to work. Therefore, a carve-out of national labor policy is needed that will support development and diffusion of this integrated approach to healthcare reform.*

***Principle 4:*** *All parties engaged in the delivery of healthcare should be held accountable and rewarded for improving the quality and costs of the services for which they are responsible and for implementing the organizational practices needed to support delivery of high quality and efficient healthcare.*


## **I. The Problem and Opportunity**

Many parts of the American healthcare delivery system are the best in the world, but as a system, it is failing. It is failing for society: we have the highest per capita spending on healthcare in the world, yet our average life expectancy lags most advanced countries and forty-six million Americans remain uninsured. It is failing for patients: witness the high number of medical errors and avoidable deaths in our hospitals. It is failing its workforce: witness the chronic shortage of registered nurses. Much of the challenge of modernizing the healthcare delivery system falls on the shoulders of the healthcare system itself. Unlocking the creativity of providers and their workforce is central to developing solutions that ensure the efficient use of society's resources to achieve quality care.

Government currently pays for 60% of all healthcare in the United States, primarily through the Medicare and Medicaid programs. With the likely enactment of national healthcare reform, this percentage will rise further. This gives government funders significant leverage to ensure that public resources are used efficiently and that all parties involved in healthcare delivery work together in a coordinated and professional manner and use state of the art management and labor relations practices. Society has an overriding interest in ensuring that caregivers are empowered to act in our interest.

Yet to date, none of the proposals put forward for reforming our healthcare system incorporate an explicit workforce strategy. This is a major shortcoming that, if left unattended, will perpetuate the hierarchical, adversarial, and specialized models of management, work organization, and labor-management relations that dominate

healthcare delivery and will continue to divert scarce public resources from the task of improving quality and controlling costs. This paper represents the first effort to outline a framework for fully engaging the healthcare workforce in the process of healthcare reform. It lays out a means of assuring that all employees, from nurse's aides and personal care workers to nurses and physicians, are engaged and working together in ways that evidence indicates are essential to achieving world class quality and productivity. It further outlines changes in practice and policy needed to ensure all management and labor organizations involved in healthcare are held accountable for implementing these state-of-the-art practices.

The framework is summarized in graphic form in Figure 1. It builds on lessons learned from innovations in workforce engagement and labor-management relations in healthcare and  other industries and proposes a set of changes in labor policy needed to support efforts to improve the delivery of healthcare in America. The framework and the reform proposal that underlies it are built on four principles, three of which are discussed in the following sections of this report. The fourth is the subject of a separate report.

## **II. Workforce Engagement, Teams, and Coordination of Caregivers**

*Principle 1: Improving quality and containing costs require an engaged workforce with the knowledge, skills, and capacity to work together in a coordinated fashion. Physicians, managers, supervisors/team leaders, nurses, and other employees need to be empowered and held accountable for reducing medical errors, improving productivity, implementing and using new technologies, and generating and implementing ideas that improve performance and reduce costs.*

In this section, we consider the ways in which workforce engagement, teams and coordination of caregivers contribute to high-quality patient care. We first consider the

evidence that teamwork and coordination improve the quality of care and that engaging members of the healthcare team in a “safety culture” is an effective, and perhaps the only, way to assure that dangerous errors can be avoided. We then describe the evidence that the development and implementation of improvement activities fundamentally requires engaged teams.

Before considering the findings of this body of research, it is important to clarify that quality measures themselves have not been well established. Some of the research focuses on process measures of quality, some on outcomes. A growing body of research focuses on the concept of patient safety, considering the health service provider as a high-reliability organization – a system that ideally responds effectively to avert potential errors and deal with rare adverse events.

#### **A. Teamwork and Engagement: Evidence on Quality and Patient Safety**

In making the case for improving the quality of the American healthcare system, the Institute of Medicine’s breakthrough report *Crossing the Quality Chasm* stressed the importance of coordination, teamwork, and the challenges of implementing these organizational features in healthcare, given the tradition of hierarchical divisions of authority and specialization in the division of labor.<sup>1</sup> Cross-disciplinary work teams are not natural to our medical care system. Medical personnel are trained and work in a hierarchical system, where professionals hold certain credentials and carry out specific tasks and functions. Individual professional accountability for decisions works in the interest of patient care, but hierarchical command-and-control shuts off potential contributions from other participants. Work groups are often hierarchical and segmented

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Institute of Medicine (2001). [Crossing the Quality Chasm](#). Washington, National Academy Press..

by profession. The knowledge of front-line care workers, including nurses, aides, and other paraprofessionals, is not reliably available either for patient care or for improving systems of care. The work culture seldom encourages work group members to question superiors' actions or share observations and recommendations beyond the scope of their own function.<sup>2</sup> Teamwork and front-line worker engagement are enacted in some settings but are not standard practice.

Most of the evidence for the relationship of teamwork to healthcare quality comes from case study reports. A 2004 review of studies of team effectiveness found only a handful of studies with sufficiently rigorous definitions of team characteristics and outcomes, making it difficult to draw conclusions.<sup>3</sup> However, there was evidence that patient care teams do a better job of coordination of care when compared with standard (non-team) care; and that project teams constituted to develop or implement innovations can be effective. Studies have demonstrated that patient care in intensive care units benefits from teamwork.<sup>4</sup> One study found that outcomes for surgical patients were better when their teams worked together in a coordinated fashion.<sup>5</sup> Communication among personnel responsible for various aspects of patient care improved outcomes for

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<sup>2</sup>

Ibid. p. 132.

<sup>3</sup>

Lemieux-Charles, L. and W. L. McGuire (2006). "What do we know about health care team effectiveness? A review of the literature." *Med Care Res Rev* **63**(3): 263-300.

<sup>4</sup>

Thomas, E. J., B. Taggart, S. Crandell, R. E. Lasky, A. L. Williams, L. J. Love, J. B. Sexton, J. E. Tyson and R. L. Helmreich (2007). "Teaching teamwork during the Neonatal Resuscitation Program: a randomized trial." *J Perinatol* **27**(7): 409-14.

<sup>5</sup>

Young, G. J., M. P. Charns, K. Desai, S. F. Khuri, M. G. Forbes, W. Henderson and J. Daley (1998). "Patterns of coordination and clinical outcomes: a study of surgical services." *Health Serv Res* **33**(5 Pt 1): 1211-36,

Gittell, J. H., K. M. Fairfield, B. Bierbaum, W. Head, R. Jackson, M. Kelly, R. Laskin, S. Lipson, J. Siliski, T. Thornhill and J. Zuckerman (2000). "Impact of relational coordination on quality of care, postoperative pain and functioning, and length of stay: a nine-hospital study of surgical patients." *Med Care* **38**(8): 807-19.

patients enrolled in a community-based long-term care program and for ambulatory diabetes patients.<sup>6</sup> Coordination and communication with informal caregivers, also members of the team, were most important for the after-care for knee-replacement patients.<sup>7</sup> Teamwork promotes better care in nursing homes.<sup>8</sup>

Some observers have compared healthcare organizations with so-called high reliability organizations (HROs), for example air traffic control towers or nuclear power plants, which build error-averting redundancies into their systems and use safety culture human resources practices to help build a safety culture that responds proactively to incidents that might lead to or involve errors.<sup>9</sup> When front-line workers feel supported rather than blamed if they bring errors to the attention of the group, errors and near-misses can be dealt with systematically. Work groups can be trained to make decisions using the expertise held by individual members regardless of rank (“deference to expertise” as opposed to deference to authority).<sup>10</sup>

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6

Temkin-Greener, H., D. Gross, S. J. Kunitz and D. Mukamel (2004). "Measuring interdisciplinary team performance in a long-term care setting." *Med Care* **42**(5): 472-81,  
Mukamel, D. B., H. Temkin-Greener, R. Delavan, D. R. Peterson, D. Gross, S. Kunitz and T. F. Williams (2006). "Team performance and risk-adjusted health outcomes in the Program of All-Inclusive Care for the Elderly (PACE)." *Gerontologist* **46**(2): 227-37.

7

Weinberg, D. B., J. H. Gittel, R. W. Lusenhop, C. M. Kautz and J. Wright (2007). "Beyond our walls: impact of patient and provider coordination across the continuum on outcomes for surgical patients." *Health Serv Res* **42**(1 Pt 1): 7-24,

Weinberg, D. B., R. W. Lusenhop, J. H. Gittel and C. M. Kautz (2007). "Coordination between formal providers and informal caregivers." *Health Care Manage Rev* **32**(2): 140-9.

8

Yeatts, D. E. and C. M. Cready (2007). "Consequences of Empowered CNA Teams in Nursing Home Settings: A Longitudinal Assessment." *The Gerontologist* **47**(3): 323-39.

9

Gaba, D. M. (2000). "Structural and Organizational Issues in Patient Safety: A Comparison of Health Care To Other High-Hazard Industries." *California Management Review* **43**(1): 83,

Tamuz, M. and M. I. Harrison (2006). "Improving patient safety in hospitals: Contributions of high-reliability theory and normal accident theory." *Health Serv Res* **41**(4 Pt 2): 1654-76.

10

Hines, S., K. Luna and J. Lofthus (2008). *Becoming a High Reliability Organization: Operational Advice for Hospital Leaders*. Prepared by the Lewin Group under Contract No. 290-04-0011. Rockville, MD.

In contrast, in the current medical culture, workers are often rewarded for pursuing “workarounds,” i.e., independent problem solving by individual workers that keeps work going smoothly. In the HRO framework, these are seen as failures rather than successes, because the work group has missed a chance to learn from an anomaly that may reveal a system weakness.<sup>11</sup> Further, the nurse, resident, or aide who makes an error or observes a potential problem may not have the standing to bring it to the attention of the person in authority without fear of blame.<sup>12</sup> The growing literature applying thinking from high reliability organizations to patient safety stresses the importance of an organizational culture that enables individual workers to feel empowered to share concerns and mistakes without fear of blame, so that the organization can focus on errors and learn from them.<sup>13</sup> Others have linked team activities to the avoidance of patient care errors.<sup>14</sup>

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Agency for Healthcare Research and Quality. AHRQ Publication No. 08-0022. February 2008.  
<http://www.ahrq.gov/qual/hroadvice/hroadvice.pdf>.

<sup>11</sup> Spear, S. J. and M. Schmidhofer (2005). "Ambiguity and workarounds as contributors to medical error." Ann Intern Med **142**(8): 627-30,

Halbesleben, J. R. B. and C. Rathert (2008). "The role of continuous quality improvement and psychological safety in predicting work-arounds." Health Care Management Review **33**(2): 134,

Halbesleben, J. R. B., D. S. Wakefield and B. J. Wakefield (2008). "Work-arounds in health care settings: Literature review and research agenda." Health Care Management Review **33**(1): 2.

<sup>12</sup> Henriksen, K. and E. Dayton (2006). "Organizational silence and hidden threats to patient safety." Health Serv Res **41**(4 Pt 2): 1539-54,

Khatri, N., A. Baveja, S. A. Boren and A. Mammo (2006). "Medical Errors and Quality of Care: From Control to Commitment." California Management Review **48**(3): 113,

Davis, R. E., M. Koutantji and C. A. Vincent (2008). "How willing are patients to question healthcare staff on issues related to the quality and safety of their healthcare? An exploratory study." Qual Saf Health Care **17**(2): 90-6,

Rogers, A. E., G. E. Dean, W. T. Hwang and L. D. Scott (2008). "Role of registered nurses in error prevention, discovery and correction." Qual Saf Health Care **17**(2): 117-21.

<sup>13</sup> Tucker, A. L. and A. C. Edmondson (2003). "Why Hospitals Don't Learn from Failures: Organizational And Psychological Dynamics That Inhibit System Change." California Management Review **45**(2): 55.

<sup>14</sup> Baker, D. P., R. Day and E. Salas (2006). "Teamwork as an essential component of high-reliability organizations." Health Serv Res **41**(4 Pt 2): 1576-98,

McKeon, L. M., J. D. Oswaks and P. D. Cunningham (2006). "Safeguarding patients: complexity science,

Although the evidence is still inconclusive, perhaps due to challenges in measuring both teamwork and outcomes, the strongest evidence for the impact of teams on safety and quality is for intensive care units, where team measures have been found to be associated with lower risk-adjusted mortality.<sup>15</sup> For example, one study found a relationship between a team measure and successful resuscitation of infants in neonatal intensive care.<sup>16</sup>

Advances are being made in the measurement of safety culture specifically.<sup>17</sup> We can look forward to more systematic research concerning the hypothesized impact of safety culture on quality indicators.

## **B. Learning Organizations Are Built on Teamwork**

Because quality of care is less than it should be in American hospitals, efforts are going forward to implement quality improvements. Government agencies, payers, and

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high reliability organizations, and implications for team training in healthcare." *Clin Nurse Spec* **20**(6): 298-304; quiz 305-6.

<sup>15</sup>

Knaus, W. A., E. A. Draper, D. P. Wagner and J. E. Zimmerman (1986). "An evaluation of outcome from intensive care in major medical centers." *Ann Intern Med* **104**(3): 410-8,

Baggs, J. G., S. A. Ryan, C. E. Phelps, J. F. Richeson and J. E. Johnson (1992). "The association between interdisciplinary collaboration and patient outcomes in a medical intensive care unit." *Heart Lung* **21**(1): 18-24,

Baggs, J. G., M. H. Schmitt, A. I. Mushlin, P. H. Mitchell, D. H. Eldredge, D. Oakes and A. D. Hutson (1999). "Association between nurse-physician collaboration and patient outcomes in three intensive care units." *Crit Care Med* **27**(9): 1991-8,

Wheelan, S. A., C. N. Burchill and F. Tilin (2003). "The link between teamwork and patients' outcomes in intensive care units." *Am J Crit Care* **12**(6): 527-34. as cited in

Sorbero, M. E., D. O. Farley, S. Mattke and S. Lovejoy (2008). Outcome Measures for Effective Teamwork in Inpatient Care. RAND. Final Report.

[http://rand.org/pubs/technical\\_reports/2008/RAND\\_TR462.pdf](http://rand.org/pubs/technical_reports/2008/RAND_TR462.pdf).

<sup>16</sup>

Thomas, E. J., J. B. Sexton, R. E. Lasky, R. L. Helmreich, D. S. Crandell and J. Tyson (2006). "Teamwork and quality during neonatal care in the delivery room." *J Perinatol* **26**(3): 163-9.

<sup>17</sup>

Singer, S., M. Meterko, L. Baker, D. Gaba, A. Falwell and A. Rosen (2007). "Workforce perceptions of hospital safety culture: development and validation of the patient safety climate in healthcare organizations survey." *Health Serv Res* **42**(5): 1999-2021,

Agency for Health Care Research and Quality (2008). Hospital Survey on Patient Safety Culture. <http://www.ahrq.gov/qual/hospculture/>,

Rogers, A. E., G. E. Dean, W. T. Hwang and L. D. Scott (2008). "Role of registered nurses in error prevention, discovery and correction." *Qual Saf Health Care* **17**(2): 117-21.

provider organizations are calling attention to quality problems, developing measures, advocating interventions like the introduction of improved information technology, and promulgating best practices. However, implementation of process improvements within the hierarchical structure of hospitals, nursing homes, and other healthcare service providers has not been easy.<sup>18</sup> Several studies using statistical measures to estimate the impact of quality improvement efforts in broad groups of providers have come up empty.<sup>19</sup> Observers familiar with other industries are not surprised: transformation of work processes is difficult to accomplish in a hierarchical fashion, when leaders determine what should be done and expect front-line workers to adopt new ways of doing their work. These observers call for importing process improvement approaches from other industries, such as the Toyota Production System, which calls for worker involvement to build system solutions from the shop floor up.<sup>20</sup>

As in any industry, continuous quality improvement in health services relies on team input, and a growing literature is emerging concerning the importance of teams to performance improvement.<sup>21</sup> First, it is logical to hypothesize that adoption of any new

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Tucker, A. L. and A. C. Edmondson (2003). "Why Hospitals Don't Learn from Failures: Organizational And Psychological Dynamics That Inhibit System Change." California Management Review **45**(2): 55, Edmondson, A. C. (2004). "Learning From Mistakes Is Easier Said Than Done." Journal of Applied Behavioral Science **40**(1): 66.

19

Weiner, B. J., J. A. Alexander, L. C. Baker, S. M. Shortell and M. Becker (2006). "Quality improvement implementation and hospital performance on patient safety indicators." Med Care Res Rev **63**(1): 29-57, Weiner, B. J., J. A. Alexander, S. M. Shortell, L. C. Baker, M. Becker and J. J. Geppert (2006). "Quality improvement implementation and hospital performance on quality indicators." Health Serv Res **41**(2): 307-34.

20

Spear, S. J. (2005). "Fixing Health Care from the Inside, Today." Harvard Business Review **83**(9): 78, Spear, S. J. and M. Schmidhofer (2005). "Ambiguity and workarounds as contributors to medical error." Ann Intern Med **142**(8): 627-30.

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Berwick, D. M. (2003). "Improvement, trust, and the healthcare workforce." Qual Saf Health Care **12**(6): 448-52,

procedure within a complex organization will work better if the work group that must use the new method embraces the change and learns together. One study found that operating room teams learned to use a complex technique more successfully when team members throughout the hierarchy were comfortable with speaking up during the learning process.<sup>22</sup> A study of nursing homes attempting to implement a new approach to end-of-life care found that the absence of a well-functioning interdisciplinary team was a predictor of failure of implementation.<sup>23</sup>

When this is applied specifically to quality improvement efforts, the importance of input from all parts of the team becomes clear – workers with different roles can see quality problems and understand potential solutions from all sides, not just top down, and the psychological safety of participants is very important in positive learning as well as in learning from mistakes.<sup>24</sup> The importance of teamwork was clearly recognized in a background study prepared for the Institute of Medicine Quality Chasm study team that sought insights from patient care work teams in various settings. This study captured

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Amalberti, R., Y. Auroy, D. Berwick and P. Barach (2005). "Five system barriers to achieving ultrasafe health care." *Ann Intern Med* **142**(9): 756-64,

Jain, M., L. Miller, D. Belt, D. King and D. M. Berwick (2006). "Decline in ICU adverse events, nosocomial infections and cost through a quality improvement initiative focusing on teamwork and culture change." *Qual Saf Health Care* **15**(4): 235-9.

Edmondson, A. C. (2003). "Speaking Up in the Operating Room: How Team Leaders Promote Learning in Interdisciplinary Action Teams." *Journal of Management Studies* **40**(6): 1419.

Watson, J., J. Hockley and B. Dewar (2006). "Barriers to implementing an integrated care pathway for the last days of life in nursing homes." *Int J Palliat Nurs* **12**(5): 234-40.

Edmondson, A. C. (2004). "Learning From Mistakes Is Easier Said Than Done." *Journal of Applied Behavioral Science* **40**(1): 66,

Edmondson, A. C., R. M. Kramer and K. S. Cook (2004). Psychological Safety, Trust, and Learning in Organizations: A Group-Level Lens. *Trust and distrust in organizations: Dilemmas and approaches*. New York, Russell Sage Foundation. Vol. 7: 239,

Tucker, A. L., I. M. Nembhard and A. C. Edmondson (2007). "Implementing New Practices: An Empirical Study of Organizational Learning in Hospital Intensive Care Units." *Management Science* **53**(6): 894.;

Scott, I. A., P. J. Poole and S. Jayathissa (2008). "Improving quality and safety of hospital care: a reappraisal and an agenda for clinically relevant reform." *Intern Med J* **38**(1): 44-55.

reports from team members that quality improvement activities worked better when the contributions of all group members were recognized and leadership was shared.<sup>25</sup>

Additional research findings indicate that participation of all members of the healthcare team is important for implementing new quality improvement initiatives.<sup>26</sup>

### **C. Conclusion: Policy Makers Need to Support Teamwork and Worker Empowerment**

Current policy concerning healthcare quality and cost focuses more on payment incentives directed to hospitals, physician groups, and other health services providers than on holding them accountable for implementing workforce strategies that will effect cost and quality improvements. These so-call value-based purchasing or pay-for-performance strategies leave to each organization the means by which it will improve quality measures or achieve benchmarks.<sup>27</sup> Despite the growing evidence that teamwork, coordination, and worker engagement are keys to achieving the quality outcomes these initiatives seek to achieve and measure, they do nothing to encourage, require, or hold organizations accountable for implementing these workforce management strategies. If

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<sup>25</sup>

Donaldson, M. S. and J. J. Mohr (2001). Exploring Innovation and Quality Improvement in Health Care Micro-Systems: A Cross-Case Analysis. A Technical Report for the Institute of Medicine Committee on the Quality of Health Care in America. [http://www.nap.edu/catalog.php?record\\_id=10096](http://www.nap.edu/catalog.php?record_id=10096).

<sup>26</sup>

Nembhard, I. M. and A. C. Edmondson (2006). "Making it safe: the effects of leader inclusiveness and professional status on psychological safety and improvement efforts in health care teams." Journal of Organizational Behavior **27**(7): 941.

<sup>27</sup> See for example

Conrad, D. A. and J. B. Christianson (2004). "Penetrating the "black box": financial incentives for enhancing the quality of physician services." Med Care Res Rev **61**(3 Suppl): 37S-68S,  
Robinson, J. C., S. M. Shortell, R. Li, L. P. Casalino and T. Rundall (2004). "The alignment and blending of payment incentives within physician organizations." Health Serv Res **39**(5): 1589-606,  
Lindenauer, P. K., D. Remus, S. Roman, M. B. Rothberg, E. M. Benjamin, A. Ma and D. W. Bratzler (2007). "Public reporting and pay for performance in hospital quality improvement." N Engl J Med **356**(5): 486-96,  
Rosenthal, M. B., B. E. Landon, K. Howitt, H. R. Song and A. M. Epstein (2007). "Climbing up the pay-for-performance learning curve: where are the early adopters now?" Health Aff (Millwood) **26**(6): 1674-82,  
Sautter, K. M., B. G. Bokhour, B. White, G. J. Young, J. F. Burgess, Jr., D. Berlowitz and J. R. Wheeler (2007). "The early experience of a hospital-based pay-for-performance program." J Healthc Manag **52**(2): 95-107; discussion 107-8..

this is as far as these accountability systems go, traditional organizational practices will continue to dominate and the opportunity to engage the workforce in improving quality, reducing errors, and controlling costs will be lost. Donald Berwick, whose Institute for Healthcare Improvement is a major force in fostering continuous quality improvement efforts in healthcare, makes this point well.<sup>28</sup>

Although major defects in the performance of healthcare systems are well documented, progress toward remedy remains slow. Accelerating improvement will require large shifts in attitudes toward and strategies for developing the healthcare workforce. At present, prevailing strategies rely largely on outmoded theories of control and standardization of work. More modern, and much more effective, theories of production seek to harness the imagination and participation of the workforce in reinventing the system. This requires a workforce capable of setting bold aims, measuring progress, finding alternative designs for the work itself, and testing changes rapidly and informatively. It also requires a high degree of trust in many forms, a bias toward teamwork, and a predilection toward shouldering the burden of improvement, rather than blaming external factors. A new healthcare workforce strategy, founded on these principles, will yield much faster improvement than at present.

In summary, the evidence to date suggests that progress will continue to remain slow unless policy makers make engagement, teamwork, and coordination of efforts of those delivering healthcare a central feature of healthcare reform *and* hold all the organizations and institutions involved in delivering healthcare accountable for embedding these features into their delivery systems. This includes the organizations and institutions that shape healthcare labor-management relations. As we will see in the next two sections, this will also require a clear break with the traditional system of labor relations, a system that was designed for 20<sup>th</sup> century industrial America, not for 21<sup>st</sup> century healthcare.

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Berwick, D. M. (2003). "Improvement, trust, and the healthcare workforce." Qual Saf Health Care 12(6): 448-52.

### **III. Labor-Management Relationships and Quality of Healthcare**

*Principle 2: Traditional adversarial union-management relationships do not foster this type of engaged and coordinated healthcare delivery system. However, despite the legal and institutional obstacles, some alternative partnership-based models have emerged and demonstrated their value for promoting engagement and coordination. These are the exception to the norm and are difficult to sustain over time. Thus, labor policy changes are needed to encourage and support labor-management partnerships.*

Over the past two decades, a large amount of evidence has accumulated showing that the traditional model of adversarial labor-management relations that was developed in 20<sup>th</sup> century industrial America does not promote the types of engagement and continuous improvements needed to achieve the high levels of quality and efficiency envisioned for the integrated and coordinated healthcare model described above. At the same time, a number of unions and employers have worked together to transform their traditional relationships in ways that promote teamwork, coordination, and improvements in both organizational performance and in the goals workers bring to their jobs and careers. We review experiences with these innovative efforts here.

#### **A. Evidence from Other Industries**

The need for fundamental changes in workplace practices and labor-management relations first became evident in the 1980s, when manufacturing industries were challenged to meet the higher standard of quality and productivity being attained by international competitors. The auto industry was among the first to feel this pressure.

In 1979 NBC ran a news special titled “If Japan can, why can’t we?” that documented the fact that Japanese firms, and Toyota in particular, could produce cars at significantly lower cost and higher quality than American firms. General Motors’ initial strategic response to this challenge was to embark on a very ambitious automation effort.

It spent, by its own estimates, \$50 billion (in 1980s dollars) in automating its factories. The result: at the end of the decade GM remained the highest cost and least productive auto producer in the United States. Even its most highly automated plants were less productive and had more defects than less automated Japanese plants operating in the United States.

Why? GM and everyone else in the auto industry learned from hard data collected at the GM-Toyota-United Auto Workers joint venture in Fremont, California, the New United Motors Manufacturing, Inc. (NUMMI) plant, that the key to achieving world class productivity and quality lies in effectively integrating the introduction of a new production system with a transformed labor-management system and an engaged workforce.<sup>29</sup> Within two years of taking over the GM plant in Fremont, California (which was one of GM's worst performing and worst labor relations plants), NUMMI was approximately 78% more productive and achieved higher quality than all other GM plants, including the company's highest tech plant located in Michigan. Indeed, NUMMI's productivity and quality matched the levels at the best non-union Japanese plant in the United States and approached the levels at Toyota's mother plant in Japan.<sup>30</sup> Moreover, NUMMI has remained an industry benchmark for productivity and quality in auto assembly for over twenty years.

Case studies at NUMMI documented how these results were achieved.<sup>31</sup>

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<sup>29</sup> John Krafick, "Triumph of a Lean Production System," *Sloan Management Review*. 1988, 30, 1, pp. 41-52. See also, Thomas Kochan, "On the Human Side of Technology," *ICL Technical Journal*, November 1988, 391-400.

<sup>30</sup> James Womack, Daniel Jones, and Daniel Roos, *The Machine that Changed the World*, New York: Rawson, 1990.

<sup>31</sup> Paul Adler, "The New 'Learning Bureaucracy': New United Motors Manufacturing, Inc." in Barry Staw and Larry Cummings (eds), *Research in Organizational Behavior*, Greenwich, CT: Jai Press, 1993, 111-194; Welford Wilms, *Restoring Prosperity: How Workers and Managers are Forging a New Culture of*

1. GM, Toyota, and the UAW negotiated a joint agreement governing union representation and the principles to guide Toyota's take over and management of the plant.
2. Toyota introduced its standard production system with the full participation of the union and engagement of the workforce.
3. Work systems were adapted to support implementation of the Toyota Production System.
4. Workers were trained in quality analysis and improvement techniques and engaged in teams to foster continuous improvement.

Subsequent research demonstrated that these results generalized across a global sample of auto assembly plants. The quantitative evidence showed that those plants that integrated the technical production system with the human aspects of the work processes (teamwork, employee participation, training, etc.) achieved higher productivity than either traditionally managed plants with equivalent levels of technology or plants with high levels of technology that did not have the complementary changes in work systems or labor relations.<sup>32</sup>

Similar results have been observed in a widely cited service sector example, Southwest Airlines, which has been the most consistently profitable airline in the United States over the past 30 plus years. It is also the most highly unionized airline in the country (over 80% of eligible employees are unionized). One of the keys to Southwest's productivity (both labor and aircraft productivity) has been its ability to turn around its planes 33% faster than its competitors (roughly 20 minutes versus 30 minutes).<sup>33</sup> Hoffer

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*Cooperation*, New York: Times Business, 1996; David I. Levine, *Reinventing the Workplace*, Washington, D.C: The Brookings Institution, 1995.

<sup>32</sup> See John Paul MacDuffie and John Krafcik, "Integrating Technology and Human Resources for High-Performance Manufacturing: Evidence from the International Auto Industry," in Thomas Kochan and Michael Useem, *Transforming Organizations*. New York: Oxford University Press, 1992, pp. 209-226.

<sup>33</sup> Jody Hoffer Gittel, *The Southwest Airlines Way*. New York: McGraw Hill, 2004.

Gittell's qualitative and quantitative study of Southwest's processes concluded that the following factors accounted for its higher productivity:

1. Achieving rapid turnarounds (time elapsed between landings and takeoffs) is critical to the business strategy of Southwest because it increases the utilization and therefore the productivity of its biggest physical assets—airplanes.
2. Therefore, from the beginning Southwest worked hard to design a ground operations process that minimized turnaround time.
3. This process requires smooth coordination across multiple occupational groups—cabin crews, ramp attendants, baggage handlers, customer service agents, schedulers and logistics personnel, etc.).

Southwest achieved and has maintained high levels of productivity and service quality and has been listed by Fortune Magazine as one of the 100 best places in the country to work. Its labor relations history also stands apart from most other large American airlines. It accepted unions without long organizing battles and has taken less than half as long to reach new labor agreements than the industry average. Continental is the only other major American airline that has consistently scored above average in service quality and in time required to reach labor agreements and, like Southwest, has been listed as one of the 100 best places in the country to work. It achieved these results only after shifting from the highly adversarial union-avoidance strategy it followed from 1983-1994, to a strategy of working with its unions and workforce to improve communications and relationships at the workplace on a day to day basis and in collective bargaining. Other large unionized airlines and labor unions have been unable or unwilling to build similar partnerships or high quality labor-management relationships,

so Southwest and Continental stand as exceptions to the general pattern in the American airline industry.<sup>34</sup>

The results from the NUMMI, Southwest, and Continental cases have been shown to generalize to industries as diverse as steel, telecommunications, apparel, and assorted other sectors. For example, a classic study of steel industry finishing lines, most of which were organized by the United Steelworkers, demonstrated that those with the most advanced forms of teamwork, pay for skills, and flexible work practices were significantly more productive than lines that had equivalent levels of technological investment but more traditional work organization arrangements and labor-management relationships.<sup>35</sup> Similarly, Black and Lynch's study of productivity in a large sample of American manufacturing industries showed that unionized plants that combined investment in technology with employee engagement were 15% more productive than non-union plants and 15-25% more productive than traditional (arms length) unionized plants. In short, these studies document significant productivity returns from engaging both union leaders and employees in introducing workplace innovations.<sup>36</sup>

## **B. Lessons from Labor-Management Partnerships**

Unfortunately, traditional labor-management relationships have a difficult time supporting these forms of collaboration and coordination. The New Deal labor relations system was built around what has been called the "job control" model: detailed and tightly specified job descriptions; clear lines of demarcation between roles and authority

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<sup>34</sup> Greg Bamber, Jody Hoffer Gittel, Thomas Kochan, and Andrew vonNordenflycht, *Up in the Air: How Airlines Can Improve Their Performance by Engaging their Employees*. Ithaca, NY: Cornell University/ILR Press, forthcoming, 2008.

<sup>35</sup> Casey Ichniowski, Kathryn Shaw, and Giovanna Prennushi, "The Effects of Human Resource Management Practices on Productivity," *American Economic Review*, 86, 1997, pp. 291-313.

<sup>36</sup> Sandra Black and Lisa Lynch, "How to Compete: The Impact of Workplace Practices and Information Technology on Productivity," *Review of Economics and Statistics*, 83, 2001, 434-45.

of managers and supervisors and of bargaining unit employees; and strict rules governing what issues managers must discuss or negotiate with union representatives and what issues are rights reserved to management discretion.<sup>37</sup>

The process for gaining union recognition also assumes and reinforces an adversarial labor-management relationship. Traditional organizing drives normally begin only if and when a significant number of workers are dissatisfied with their treatment by the employer; managers strongly resist organizing efforts; and the process specified in the National Labor Relations Act often is long, subject to legal delays, generates a great deal of stress and conflict, and is costly to both unions and employers. Unions are successful in winning a contested organizing election and negotiating a first contract in less than 20% of all organizing drives and in less than 10% if the employer resists strongly enough to cause the union to file an unfair labor practice charge.<sup>38</sup> It is very difficult to build a cooperative union-management relationship following such an intense battle.

Notwithstanding these constraints, evidence like that summarized above has led a number of labor and management leaders to work together in efforts to transform their traditional adversarial relationships in ways that support workforce engagement, teamwork, and coordination. Indeed, such efforts have waxed and waned throughout most of America's labor management history. In the 1920s, a number of leading railroads and their unions worked together to put their history of violent conflicts behind them as they sought to expand passenger service across the country. In World War II, productivity and safety committees were created in plants across the country to foster

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<sup>37</sup> See Thomas A. Kochan, Harry C. Katz, and Robert B. McKersie, *The Transformation of American Industrial Relations*. New York: Basic Books, 1986.

<sup>38</sup> John-Paul Ferguson, "The Eyes of the Needles: A Sequential Model of Union Organizing Drives, 1999-2004." *Industrial and Labor Relations Review*, forthcoming.

production and ensure that those contributing to the war effort labored under safe working conditions.

As noted in the prior section, another wave of labor-management innovation occurred in the 1980s and 1990s in response to intensified competitive pressures in steel, auto and other manufacturing industries. But not all partnerships survived indefinitely. Indeed, many did not, at least in the forms in which they were first conceived. Consider the Saturn Corporation, perhaps the most ambitious and visible example of a labor-management partnership conceived in the 1980s.<sup>39</sup> Saturn was created as a new division of General Motors in 1985 and began producing cars in 1990. It was designed as a partnership from the outset with a joint “team of 99” working together for several years to design both a new organization and a new car – a small American car, something GM could not produce profitably at the time. Saturn was to be a “new kind of organization” designed with partnership principles from top to bottom. Union partners worked side by side with executives in manufacturing, marketing, human resources, product development, and other functions. Union representatives served on both a strategic advisory committee and a manufacturing council. Work teams were jointly led by labor and management partners.

Saturn’s early years were highly successful. The concept of a “new kind of organization and a new kind of car” resonated well with American car buyers, and Saturn vehicles achieved top quality ratings from consumers. But leadership turnover, ambivalence about sharing power as completely as called for in the Saturn agreement, and delays in authorizing new products eventually led to the demise of the most

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<sup>39</sup> Saul Rubinstein and Thomas Kochan, *Learning from Saturn*. Ithaca, NY: Cornell University/ILR Press, 2001.

ambitious features of the partnership. In 2003 GM and the UAW brought the Saturn Division back under the national collective bargaining agreement. Still, two decades after its initial conception, labor and management leaders at Saturn were working together in a modified and simplified partnership that carried over many of the principles of the original model.

A similar ambitious partnership effort occurred in the steel industry in the 1990s. During the 1980s the parties had implemented at the plant level labor-management participation teams that had in some instances been quite successful in dealing with production problems. However, given the decline of the industry, a new approach that took place above the shop floor and at the strategic level was needed. The new concept that emerged was labeled “New Direction” and envisioned a strategic partnership with each of the large steel companies. Inland Steel, now part of Acelor-Mittal Corporation, was the first company to agree to the New Direction concept which stipulated that: the union would be apprised of all important capital decisions; a union nominated director would sit on the corporate board; a standing committee of the board would track the partnership; the company would maintain a neutral posture in the face of union organizing; employment continuity would be assured; and the parties would work cooperatively to increase productivity. The agreement called for joint labor-management committees from the top of the organization to the shop floor.

In the early years this partnership flourished, but it floundered when the union became aware of the company’s bid to acquire assets in Venezuela. The union believed that the company had violated the neutrality provision during organizing campaigns on the distribution side of the business, and the parties had to resort to interest arbitration

when they could not agree on terms for a wage reopener. Thus in this case, the combination of conflicts over strategic business decisions and negotiations brought an end to the partnership.


Another partnership that proved initially successful but ultimately unsustainable involved AT&T and the two unions that represent its workforce, the Communications Workers of America (CWA) and the International Brotherhood of Electrical Workers Union (IBEW). AT&T and its unions went through a number of iterations of union and worker involvement in decision-making, beginning with a Quality of Work Life (QWL) program established contractually in 1983. After various organizational stresses, not the least of which were the breakup of the Bell system and rapid and substantial technological change, undermined the QWL program, the parties revived labor-management cooperation in the form of Workplace of the Future (WPOF) in 1992. The WPOF partnership involved union-management committees at the top level of the corporation as well as within business units where significant business decisions were being made. In addition, union members participated in teams and committees, some based in departments and some focused on particular projects. WPOF provided a system for integrating collective bargaining and partnership, by including a high-level labor-management committee that could sanction local experiments that conflicted with collective bargaining agreements.

While the Workplace of the Future improved organizational outcomes for the company, workers, and customers, it fell victim to the company's decision to divest its manufacturing operations (creating the Lucent Corporation) and its regional phone operations, without any advance notice to the unions. For awhile, the partnership

continued to struggle along at the pared down AT&T and at the spun-off manufacturing operations at Lucent, taking different forms depending on the business context. It ultimately collapsed at AT&T; the immediate cause was withdrawal by CWA in the face of continued allegations over management's conduct in union organizing campaigns in the parts of AT&T's business that were growing and represented the future of the company.

While these broad-based comprehensive partnerships have proved hard to sustain, more limited efforts focused on specific issues such as joint training, safety and health, and in cases like Southwest and NUMMI, operational issues like quality and performance improvement have been more enduring. Data from a representative national sample of union-management relationships show that comprehensive efforts to transform traditional relationships at the workplace, in collective bargaining, and in strategic level interactions like those described above are underway in less than 10% of contemporary union-management relationships. Those going down this path, however, report higher levels of innovation in bargaining, work practices, and higher levels of cooperation and rates of improvement in their relationships.<sup>40</sup>

### **C. Labor-Management Partnerships in Healthcare**

Healthcare labor relations mirror the pattern found across the rest of the economy with traditional labor-management relations being the norm and efforts to build partnerships still the exception. We review  experiences in healthcare labor relations below.

#### Local 1199SEIU and the New York League of Voluntary Hospitals and Nursing Homes

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<sup>40</sup> Joel Cutcher Gershenfeld and Thomas Kochan, "Taking Stock: Collective Bargaining at the Turn of the Century," *Industrial and Labor Relations Review*, October, 2004.

One longstanding example of a labor-management partnership was initiated by Local 1199SEIU of the Service Employees International Union (SEIU) and a multi-employer association, the New York League of Voluntary Hospitals and Nursing Homes. These organizations created a formal partnership in 1997, funded by the League contract and called the Labor-Management Project. The Project formally covers over 125,000 members of the Local working in dozens of non-profit hospitals and nursing homes that are members of the League. The Labor-Management Project sits within a broad, strategic alliance, a cooperative relationship aimed at improving patient care, assisting workers to retain their employment if hospitals close, protecting and increasing public funding for the healthcare system, and achieving union-building goals. At the facility level, labor-management partnership activities take a variety of forms, depending on the interests and readiness of management and union leaders. In some cases, this has primarily meant improving labor relations and has included the use of interest-based problem solving skills. Other facilities have gone much further and have undertaken joint projects focused on expanding opportunities for worker participation to improve the quality and safety of patient care, the quality of jobs, and the facility's patient satisfaction scores. In some facilities, other unions (both the Committee of Interns and Residents and the New York State Nurses Association) have joined hospital-based partnership activities. A recent report on the results of partnerships between these unions and five medical centers in New York City cited a variety of positive results from partnership projects and activities, including increased patient and employee satisfaction, reduced grievance rates, and cost savings from specific project initiatives.<sup>41</sup>

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<sup>41</sup> Report of the International Action Research Project (no date).

In 2002, the League and the Local negotiated a limited neutrality agreement covering new union organizing. Some individual members of the League have also reached organizing agreements with the Local that are more advantageous for the union, a phenomenon that is explicitly allowed by the League agreement.

#### Local 115 and Allina Health Systems

Allina Health Systems in Minnesota and SEIU Local 115 have recently signed a partnership agreement after a larger multi-employer and multi-union effort proved too difficult to sustain. Allina was originally part of a multi-employer and multi-union partnership involving fifteen hospitals and Local 115 and the Minnesota Nurses Association. That more complex partnership lasted for about five years and was able to support hospital-specific teamwork and engagement initiatives that reduced medical errors and improved quality. Eventually, however, the cross-hospital/cross-union partnership could not be held together, in part due to conflicts within the employer group and between the two unions. Nonetheless, Allina management and SEIU have recently embarked on their own approach to partnership.<sup>42</sup> This partnership is still at an early stage and thus far has focused on service and other performance improvements, improved workforce development, income security, and management neutrality to minimize labor-management conflict around union organizing.

#### Kaiser Permanente Labor-Management Partnership

The largest (in terms of numbers of workers), most complex (in terms of numbers of unions and the geographic scope and complexity of the employer), and most ambitious (in terms of the range of issues addressed) labor-management partnership in the United

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<sup>42</sup> See Gil Preuss and Ann Frost, “The Rise and Decline of Labor-Management Cooperation: Lessons from Healthcare in the Twin Cities”, California Management Review, Winter 2003.

States today is between Kaiser Permanente and the Coalition of Kaiser Permanente Unions (CKPU).<sup>43</sup> The partnership began in 1996 when top executives at Kaiser and national union leaders representing nine different national unions and twenty-seven locals agreed to work together both to reverse a deteriorating labor-management relationship and to, among other goals, improve the quality of patient care.

This partnership has endured for over a decade. During this decade, the parties negotiated two highly innovative national level collective bargaining agreements. Negotiations over both agreements made extensive use of interest-based problem solving tools and processes to address a wide range of healthcare and workforce issues, including the appropriate scope of professional practice, service quality, performance improvement, work and family balance, workforce development, attendance and absenteeism, and fringe benefits. The parties also negotiated a comprehensive agreement governing the introduction of new electronic medical records technologies, a very high priority for Kaiser Permanente and an issue that raised considerable employment security and adjustment concerns within the workforce.

Since the partnership, grievance rates have declined and employee satisfaction with Kaiser as a place to work and as a healthcare provider and with their unions have all increased. The parties also jointly designed the work system and opened a new hospital in record time; negotiated a restructuring of an optical laboratory both to keep it open and to improve its productivity and profitability; and jointly addressed a number of budgetary crises. These efforts helped Kaiser turn around its financial performance: Kaiser registered eight years (2000-07) of profits following several years of losses.

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<sup>43</sup> This summary is drawn from Kochan, Eaton, McKersie, and Adler, *Healing Together: The Labor Management Partnership at Kaiser Permanente*.



One of the key goals of the partnership was to use partnership principles and processes to engage front-line workers more fully in on-going efforts to improve the healthcare delivery process. At the end of the partnership's first decade, approximately 40% of the unionized workforce reported being involved in some form of partnership activity. The one analysis of the effects of employee involvement on patient outcomes completed to date showed that higher levels of involvement were positively associated with improvements in child and adult immunization rates, breast cancer screening rates, and lipid testing rates.<sup>44</sup> A similar quantitative analysis found that employee engagement and partnership support increased the performance improvements achieved with the introduction of the new medical information technologies.<sup>45</sup> To our knowledge, these are the only studies carried out to date that examine the effects of labor-management partnerships and employee engagement on patient outcomes.

One important feature of the partnership agreement is the provision governing labor and management behavior when new groups of workers seek to organize. As noted above, this issue has been one of the Achilles' heels for partnerships. The partnership agreement at Kaiser Permanente addresses this issue by specifying:

The parties to this agreement believe that Kaiser Permanente employees should exercise free choice and decide for themselves whether or not they wish to be represented by a labor organization.

Kaiser Permanente has no objection to a union signatory to this agreement becoming the bargaining representative of its people. Where a signatory union becomes involved in organizing KP employees, the employer will maintain a strictly neutral position.

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<sup>44</sup> Adam Seth Litwin, "Quantifying the Line from Partnership to Performance at Kaiser Permanente," MIT Institute for Work and Employment Research Working Paper, 2008.

<sup>45</sup> Adam Seth Litwin, "Essays on Information Technology and the Employment Relationship: Work, Workers, and IT in American Healthcare," PhD Dissertation, MIT Institute for Work and Employment Research, 2008.



It is the intention of the parties that employees' desire for exclusive bargaining representation be resolved in the most expeditious manner possible. Whenever a majority of employees in a unit the parties agree to be appropriate express clearly and unambiguously the wish to be represented by a signatory union, Kaiser Permanente agrees to recognize that union. An umpire shall be selected who will have the final authority to resolve ambiguities as to majority status and disagreements as to unit appropriateness.

Kaiser Permanente reserves the right to speak out in any appropriate manner when undue provocation is evident in an organizing campaign. Kaiser will encourage subcontractors, vendors, mergers and alliance partners to adopt the same policy regarding the union representation of their employees.

In 1999 the parties further specified the procedures governing this process in a memorandum of agreement that prohibits managers and union representatives involved in organizing from portraying each other negatively or engaging in misrepresentation or personal attacks and requires all parties to keep organizing campaigns free from fear and intimidation and any discrimination against individual workers. The agreement also covers arrangements for determining bargaining units, rules governing union access to employer property, procedures for using card check to verify majority status, and a dispute resolution process that resolves issues arising during an organizing campaign through arbitration, including, if necessary, the outcome.

This process has worked well. Over the first eight years, approximately twenty nine new bargaining units covering 7,400 workers gained recognition. Unions were successful in gaining recognition through the card check process in about 80% of the cases (20% resulted in no union because a majority declined to sign authorization

cards).<sup>46</sup> This 80% rate is consistent with the success rates with card check agreements in other settings.<sup>47</sup>

The research team that studied the first decade of the Kaiser Permanente labor-management partnership judged it a success – but still a work in progress. The partnership turned around dangerously deteriorating labor-management relations; deepened the organizational capacity of Kaiser to meet challenges and crises as they arose; demonstrated that workers, unions, managers, and physicians could work together in delivering high quality healthcare; and yielded significant benefits for management, employees, and unions. This partnership thus represents an important model of successful collaboration to improve healthcare by engaging the workforce and its union representatives.

#### **D. Traditional Adversarial Relationships in Healthcare**

Partnerships like those at Kaiser Permanente, the League of Voluntary Hospitals in New York, and Allina in Minnesota are still the exception in healthcare labor relations. Many more examples exist of highly contentious labor-management relationships in healthcare. Consider the situation at Yale-New Haven Hospital. In March 2006, SEIU Local 1199 New England, Yale-New Haven Hospital and community leaders signed an agreement that governed organizing of low-paid service workers and included a requirement of neutrality by the employer and a code of conduct for both parties at the hospital. The agreement also provided for training for local residents. This agreement

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<sup>46</sup> Adrienne E. Eaton, Saul A. Rubinstein and Thomas A. Kochan, “Balancing Acts: Dynamics of a Union Coalition in a Labor Management Partnership, *Industrial Relations*, vol. 47, No. 1 (January, 2008, p. 31).

<sup>47</sup> See Adrienne E. Eaton and Jill Kriesky, “Organizing Experiences under Union-Management Neutrality and Card Check Agreements,” Report to the Institute for the Study of Labor Organizations, George Meany Center for Labor Studies, April, 1999.

was the product of a bitter fight that the union had waged for several years. The union had successfully allied itself with New Haven residents and local politicians and clergy to examine the hospital's financial practices and to block the building of a new cancer center and had argued that poor pay and poor patient care were linked. While these events were taking place, Yale University, although formally a separate entity from the hospital, found itself pulled into the battle. After the neutrality agreement was signed, the union began an organizing campaign, but in December 2006, an arbitrator postponed the election based on her finding that the hospital had violated both federal labor law and the organizing agreement by allowing managers to conduct mandatory workplace meetings about the organizing drive. The prolonged conflicts at the hospital eventually doomed efforts to build a partnership at both the hospital and the university.

Cedars Sinai, one of the largest hospitals in Los Angeles and one recognized as a leader in healthcare research and teaching, is another illustration of the lengthy conflict that can occur when an employer resists its employees' attempts to unionize. Cedars Sinai has traditionally been a high wage employer, stating its intent to pay in the upper 20% of the area's wage distribution. At the same time it has consistently fought unionization of its staff, starting in 1976 with interns and residents who sought to organize. The hospital successfully argued before the National Labor Relations Board that interns and residents were not "employees" covered under the Act because they were also students being trained by the hospital. In 2002, the hospital again successfully fought a unionization effort, this time by challenging the results of an election in which the majority of nurses voted to join the California Nurses Association (CNA). The hospital and the CNA have continued their stand-off ever since. CNA has argued that the

hospital intimidates union supporters and relies on union avoidance consultants to the detriment of patient care. In return, the hospital's chief executive has argued it is the union that "engages in very aggressive tactics" and that "we believe that our ability to deal directly with our staff, nurses and others is the best way for us to achieve the institution's mission and achieve high quality health care."<sup>48</sup>

Another example of a long drawn out organizing battle involves a 650 person service and maintenance unit at Enloe Health Care Center in California. Following a long and intense organizing battle involving a corporate campaign by the union, workers voted to be represented by SEIU in 2004. But management then spent an estimated three million dollars in legal fees contesting the election results. Only after three years of consistent rulings by the National Labor Relations Board and the United States Court of Appeals upholding the election results, layoffs of over 170 employees, and the replacement of the CEO did the parties sit down to begin bargaining a first contract. Four years after the election, bargaining for a first contract continues under threat of a strike by the union.<sup>49</sup>

## **E. Conclusion**

While SEIU has successfully negotiated neutrality agreements in a limited number of hospital chains, most notably for the California operations of Tenet and Catholic Health West, most hospitals have remained resistant to union organizing.

Where such agreements have been negotiated, they have been criticized by some unions

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<sup>48</sup>Lawrence Darmiento, "Unions Step up Drive to Organize Cedars' Nurses," *Los Angeles Business Journal*, January 27, 2003.

<sup>49</sup> The case has been reported at various stages in the local newspaper, the Chico Enterprise Record. See for example Larry Mitchell, "Who's the Bully in the Enloe Battle," and Larry Mitchell, "Unions-Enloe Agree Over Legal Battle, available at [www.chicoer.com/indepth/enloe/ci-3528047](http://www.chicoer.com/indepth/enloe/ci-3528047) and [5140273](http://www.chicoer.com/indepth/enloe/ci-5140273). Bargaining information comes from Enloe News Releases available at [www.enloeorg/news\\_and\\_publications/2008/2008-03-28.asp](http://www.enloeorg/news_and_publications/2008/2008-03-28.asp).

that are committed to traditional adversarial models for organizing and representing employees. As will be discussed more fully in the next section, they have also been challenged in court by various anti-labor groups on the grounds that they violate one or another of the adversarial doctrines built into existing labor law. These sources of opposition need to be addressed directly if labor-management partnerships that begin at the organizing stage and carry through to the negotiation of agreements and management of day to day relationships are to spread and be sustained – that is, to become standard features in healthcare labor-management relations.

In summary, labor-management partnerships have demonstrated their potential to support workforce engagement and related activities that promote superior performance in healthcare and in other settings. Yet labor-management partnerships remain the exception in American labor relations and are hard to sustain. Some reasons for this reflect the adversarial culture of management and union relations built up over the years in the United States. This culture is assumed and built into the legal principles and practices governing the organizing and negotiating processes and the ongoing, day to day interactions among different occupational and professional groups, supervisors, and managers at the workplace and in higher level strategic union-management relationships. The factors that create and reinforce the adversarial culture of labor-management relations need to be addressed if the types of quality labor-management relationships needed to promote and sustain high levels of employee engagement, teamwork, and coordination in the delivery of healthcare are to become the norm, rather than the exception.

## **IV. Labor Policy Reforms Needed to Support High Quality Healthcare**

*Principle 3: Labor law is currently based on adversarial principles that will make it difficult, if not impossible, for this model of healthcare reform to work. Therefore, a carve-out of national labor policy is needed that will support development and diffusion of this integrated approach to healthcare reform.*

We identify below the challenges current labor law poses to a partnership approach to healthcare reform. We then address possible legislative reforms that would enable and encourage collaboration between management and employees in healthcare.

### **A. Impediments to a Partnership Approach to Healthcare Reform**

Federal labor law was designed to fit an industrial workforce and economy that presupposed clear lines of demarcation between workers and managers and among occupational groups. It assumes and reinforces an adversarial relationship between workers and managers. The legal doctrines that stem from this assumption actually discourage and limit the workforce engagement, teamwork, and coordination needed to address the quality and cost issues in healthcare in unionized, partially unionized, and nonunion work settings. If meaningful healthcare reform is to be achieved, these limitations on the ability of workers to organize effectively and to add their voices to a collaborative approach to healthcare must be addressed.

When employers and unions have tried to find a way to avoid the acrimonious and economically damaging labor disputes that often mark organizing and bargaining, several legal theories have been asserted to undermine those attempts. These arguments threaten the ability of workers and employers to use collaborative techniques in three primary areas: (1) organizing and recognition procedures; (2) contract negotiations, and (3) day

to day interactions among employees, supervisors, managers, and physicians. These are all critical stages for a collaborative approach to healthcare.

### 1. Challenges to Neutrality Agreements

Over the past 30 years, unions and employers increasingly have entered into neutrality agreements when it has become clear that a collaborative rather than an adversarial relationship makes economic sense for both unions and employers.<sup>50</sup> A “neutrality agreement” generally refers to a commitment by an employer to remain “neutral” during an organizing drive, rather than actively oppose the union. Thus, a neutrality agreement may include a provision that the employer will remain silent regarding its views on unionization. Or a negotiated neutrality clause may impose conditions on both the employer and union, such as limits on hostile rhetoric and mutually agreeable ground rules for organizing campaigns (for example, providing for vetting of campaign materials and information sharing).<sup>51</sup> These agreements may also provide access rights to union organizers that would not otherwise be available. Additionally, neutrality agreements are often accompanied by an agreement providing that the employer will recognize the union as the collective bargaining representative of the employees upon a majority showing of support through a “card check” or through an election that is not conducted by the National Labor Relations Board (non-Board election).<sup>52</sup>

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<sup>50</sup> See Adrienne Eaton and Jill Kriesky, *Union Organizing Under Neutrality and Card Check Agreements*, 55 Indus. & Lab. Rel. Rev. 42, 43 (2001).

<sup>51</sup> Professors Eaton and Kriesky analyzed 132 neutrality agreements negotiated by twenty-three different national unions and found that almost all of the agreements (93%) included an explicit employer commitment to neutrality. Eaton & Kriesky, 55 Indus. & Lab. Rel. Rev. at 46-47.

<sup>52</sup> Of the 132 agreements reviewed by Professors Eaton and Kriesky, 65 percent included both a statement of neutrality and a provision to recognize union majority status through card check procedures. 55 Indus. & Lab. Rel. Rev. at 46-47.

a. Section 8(a)(2) of the NLRA

In several instances where unions and employers have agreed to neutrality provisions, those agreements have been challenged as illegal under the National Labor Relations Act (NLRA). Opponents of unionization have argued that an employer's agreement to refrain from making negative statements about the consequences of unionization, and to allow union representatives access to its facilities, constitutes employer assistance to the union which is unlawful under Section 8(a)(2) of the NLRA, 29 U.S.C. §158(a)(2).<sup>53</sup>

Section 8(a)(2) makes it an unfair labor practice for an employer "to dominate or interfere with the formation or administration of any labor organization or contribute financial or other support to it."<sup>54</sup> This section historically was intended to deal with so-called "company unions" that are sponsored and controlled by employers. For example, when Senator Wagner introduced the bill in 1934 that eventually resulted in the NLRA, he remarked on the rise of employer-dominated unions, often called "work councils" or "employee representation plans."<sup>55</sup> Senator Wagner described the majority of these employee representation plans as "spurious unions," and described how they undermined "genuine freedom of self-organization."<sup>56</sup> Legal scholars have argued that this legislative

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<sup>53</sup> For example, where Tenet and SEIU agreed to certain pre-election procedures in hospitals in California and Florida, which included access rights for union organizers and a procedure for vetting campaign literature, the agreement was challenged on the theory that the agreement was illegal assistance by the employer to the union. Ironically, the agreement in question did not require employer neutrality. Rather, it contained non-disparagement provisions, but it specifically permitted the employer to voice its opposition to unionization.

<sup>54</sup> 29 U.S.C. §158(a)(2) (2000).

<sup>55</sup> 90 Iowa L. Rev. at 849-50 (citing To Create a National Labor Board: Hearings on S. 2926 Before the Senate Comm. on Educ. & Labor, 73d Cong. 721 (1934), *reprinted in* 1 NLRA Leg. History of the National Labor Relations Act (hereinafter "NLRA Leg. Hist.") at 767, 770).

<sup>56</sup> *Id.* at 850, 851 (citing National Labor Relations Board: Hearings on S. 1958 Before the Senate Comm. on Educ. & Labor, 74th Cong. 40 (1935), *reprinted in* 1 NLRA Leg. Hist. at 1373, 1416; Sen. Rep. No. 74-573, at 9-11 (1935)).

history demonstrates that Congress' purpose in prohibiting employer-dominated unions was not to oppose "cooperation or accommodation between labor and management," but, rather, to ensure that employers deal with independent labor organizations.<sup>57</sup>

However, the line between employer-union cooperation and unlawful employer assistance in the organizing context has sometimes been difficult to ascertain. Generally, employer support that looks like domination or interference with employees' rights is more likely to be held unlawful. Examples of unlawful employer support include helping the union to solicit signed authorization cards,<sup>58</sup> designating particular employees to assist the union its organizing effort,<sup>59</sup> or convening a meeting between the union and employees at which supervisors are present and able to observe the employees' reactions.<sup>60</sup> Examples of permissible employer-union cooperation during organizing drives include arranging a meeting between the union and employees on company premises or allowing the union to solicit authorization cards during the workday.<sup>61</sup>

More recently, Section 8(a)(2) has been the basis for stepped-up attacks on agreements between employers and unions that provide for employer neutrality, vetting of campaign materials and/or the granting of heightened access rights to union organizers. The theory behind such challenges has been that these agreements constitute employer "support." Under the NLRA, however, to be unlawful, the employer support

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<sup>57</sup> *Id.* at 851.

<sup>58</sup> *See Packing House & Indus. Servs. v. NLRB*, 590 F.2d 688, 694 (8th Cir. 1978) (finding Section 8(a)(2) violation when employer assisted in efforts to solicit signed cards during worktime); *Windsor Place Corp.*, 276 N.L.R.B. 445, 448-49 (1985) (same); *B.F.G. Gourmet Foods, Inc.*, 236 N.L.R.B. 489, 491 (1978) (same).

<sup>59</sup> *See NLRB v. Keller Ladders S., Inc.*, 405 F.2d 663, 667 (5th Cir. 1968) (finding Section 8(a)(2) violation).

<sup>60</sup> *See NLRB v. Vernitron Elec. Components, Inc.*, 548 F.2d 24, 27 (1st Cir. 1977) (finding Section 8(a)(2) violation); *Duane Reade, Inc.*, 338 N.L.R.B. 943, 943-44 (2003) (same).

<sup>61</sup> *See, e.g., Tecumseh Corrugated Box Co.*, 333 N.L.R.B. 1, 3, 6 (2001); *New England Motor Freight Inc.*, 297 N.L.R.B. 848, 851-52 (1990).

must have the effect of “dominat[ing] or interfer[ing]” with the union.<sup>62</sup> Neutrality agreements bargained at arms-length are unlikely to be marked by such employer domination. We are unaware of any instance in which a neutrality agreement, standing alone, has been deemed unlawful assistance.

In situations involving rival unions, Section 8(a)(2) has also been used to prohibit an employer from discriminating between the unions,<sup>63</sup> and agreements that promise access, information, or other aids to organizing to some unions but not others have been challenged as unlawful.<sup>64</sup> The Board has held that an employer that agrees to allow a particular union access to its property has no affirmative obligation to offer a rival union the same access arrangement; the burden is on the rival union to request the same agreement.<sup>65</sup> However, this begs the question of what constitutes the “same” agreement. If an employer and union have negotiated a series of agreements, including agreements on access and neutrality, but also including agreements on issues such as future organizing campaigns at additional facilities and principles for negotiation of first contracts, the Board’s Division of Advice has signalled that the rival union may only request and agree to the specific access and neutrality provisions – without agreeing to

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<sup>62</sup> 29 U.S.C. §158(a)(2).

<sup>63</sup> This legal doctrine stems from *Midwest Piping & Supply Co.*, 63 N.L.R.B. 1060, 1069-70 (1945), in which the Board found that an employer violated Section 8(a)(2) by recognizing one of two competing unions after both had filed election petitions. However, the Board later held that there was no unlawful employer assistance where an employer rejected the “colorable claim” of a rival union in an initial organizing setting and instead recognized a union representing an uncoerced majority of employees. *Bruckner Nursing Home*, 262 N.L.R.B. 955 (1982). One legal scholar has argued that, if an employer does not unlawfully assist a union by recognizing it – even in the face of a rival union’s claim – an employer’s “less intrusive decision – to remain neutral while a union seeks to garner such majority card support – is similarly not an unlawful preference for one union over another.” James J. Brudney, *Neutrality Agreements and Card Check Recognition: Prospects for Changing Paradigms*, 90 Iowa L. Rev. 819, 846 (2005).

<sup>64</sup> See, e.g., *Kosher Plaza Supermarket*, 313 N.L.R.B. 74 (1993) (employer’s grant of unequal access to one union over another during organizing campaign violates Section 8(a)(2)).

<sup>65</sup> See *Detroit Medical Ctr. Corp.*, 331 N.L.R.B. 878 (2000).

terms concerning other matters such as future organizing or negotiation of contracts. This, of course, defeats the efforts of the union and employer to resolve a number of issues simultaneously and may remove incentives for employers and unions to agree to the neutrality and access provisions. For example, an employer may have agreed to access and neutrality provisions in exchange for concessions in other agreements and may not gain the benefit of that bargain should a rival union request the same rights.

Although neutrality agreements between employers and unions do not constitute unlawful employer assistance under current labor law, repeated challenges to such agreements under Section 8(a)(2) are likely to continue.

b. Section 8(c) of the NLRA

Section 8(c) of the NLRA provides qualified protection for employer speech during an organizing campaign: an employer's expression of any view, argument, or opinion is not an unfair labor practice, so long as that expression "contains no threat of reprisal or force or promise of benefit." 29 U.S.C. §158(c).<sup>66</sup> However, nothing in the NLRA prohibits an employer from remaining silent during an organizing campaign or requires the employer actively to oppose unionization.<sup>67</sup>

Nevertheless, some employers have argued that employer neutrality runs afoul of Section 8(c) because neutrality constitutes a waiver of a fundamental employer right

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<sup>66</sup> Section 8(c) was enacted in 1947 after the Supreme Court warned that Board restrictions on noncoercive employer speech raised constitutional questions. *NLRB v. Va. Elec. & Power Co.*, 314 U.S. 469, 477-79 (1941); see also *Thomas v. Collins*, 323 U.S. 516, 531-32 (1945).

<sup>67</sup> See *International Union v. Dana Corp.*, 278 F.3d 548, 558-559 (6th Cir. 2002) (enforcing arbitration award finding that employer had violated neutrality agreement); *HERE Local 2 v. Marriott Corp.*, 961 F.2d 1464, 1470 (9th Cir. 1992) (neutrality clause was enforceable in Sec. 301 action). Moreover, to the extent an employer enters into a neutrality agreement voluntarily, this should constitute a voluntary, intelligent and knowing waiver of any employer First Amendment rights that may be implicated. 90 Iowa L. Rev. at 854 (citing *D.H. Overmyer Co. v. Frick Co.*, 405 U.S. 174, 187 (1972)).

protected by the NLRA and is thus contrary to federal labor policy.<sup>68</sup> In *Chamber of Commerce of United States v. Brown*, a case recently decided by the U.S. Supreme Court which involved a state prohibition on an employer’s use of state funds “to assist, promote, or deter union organizing,” the Chamber of Commerce argued that the NLRA affirmatively “protects and encourages noncoercive employer speech about union organizing.”<sup>69</sup> But the legislative history shows that Section 8(c) was intended merely to ensure that non-threatening employer speech, standing alone, could not form the basis of an unfair labor practice charge against the employer.<sup>70</sup>

In *Chamber of Commerce*, the Court recognized that Section 8(c) was a “respon[se] to particular constitutional rulings of the NLRB,” and also that it “merely implements the First Amendment.”<sup>71</sup> However, the Court also found that the enactment of Section 8(c) “manifested a ‘congressional intent to encourage free debate on issues dividing labor and management.’”<sup>72</sup> The Court stated that this “policy judgment” by Congress was one “favoring uninhibited, robust, and wide-open debate in labor disputes.”<sup>73</sup> Significantly, the Court made clear that it was not engaging in a constitutional analysis and was not considering whether a neutrality restriction on use of state funds (or whether an absolute employer neutrality requirement) violated the First

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<sup>68</sup> *Dana Corp.*, 278 F.3d at 558.

<sup>69</sup> *Chamber of Commerce v. Brown*, Sup. Ct. No. 06-939, Pet. Br. at 14.

<sup>70</sup> S. Rep. No. 80-105, at 23 (1947), reprinted in 1 NLRB, Legislative History of the Labor-Management Relations Act, 1947, at 407, 429 (1948).

<sup>71</sup> 128 S. Ct. 2408, 2413 (2008) (quoting *NLRB v. Gissel Packing Co.*, 395 U.S. 575, 617 (1969)).

<sup>72</sup> *Id.* (quoting *Linn v. Plant Guard Workers*, 383 U.S. 53, 62 (1966)).

<sup>73</sup> *Id.* at 2414 (quoting *Letter Carriers v. Austin*, 418 U.S. 264, 272-73 (1974)). The Court relied on this Congressional intent in finding the challenged state law preempted by federal labor law, reasoning that Section 8(c) demonstrated that Congress intended “to leave noncoercive speech unregulated,” and thus California could not make the policy judgment that “partisan employer speech necessarily interfere[s] with an employee’s choice about whether to join or to be represented by a labor union.” *Id.* (internal quotations omitted).

Amendment.<sup>74</sup> And the Court certainly did not hold that an employer may not voluntarily choose to remain neutral during a union organizing campaign.

Opponents of neutrality agreements also argue that such agreements violate the NLRA because an employer's agreement to remain silent during a union organizing campaign necessarily undermines the *employees'* rights under Section 7 of the NLRA to engage in concerted activity without coercion or interference. But nothing in the NLRA suggests that employees have an affirmative right to require their employer to educate them about anti-union arguments in order for them to exercise fully their Section 7 rights.<sup>75</sup>

c. Section 302 of the LMRA

Finally, we note that neutrality agreements also recently have been challenged under Section 302 of the Labor-Management Relations Act (LMRA), 29 U.S.C. §186, a criminal statute that prohibits an employer from giving a union “any money or other thing of value.” Even though Section 302 was enacted to prohibit bribes of union officials,<sup>76</sup> it has been used to try to criminalize labor-management neutrality agreements. For example, in *Adcock v. UAW*, a RICO case pending in the Fourth Circuit, the Right to Work Foundation argues that, by entering into and implementing an agreement providing for employer neutrality during organizing campaigns and allowing recognition of the

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<sup>74</sup> *Id.* (“Constitutional standards, while sometimes analogous, are not tailored to address the object of labor pre-emption analysis ...”).

<sup>75</sup> The legislative history of Section 8(c) reflects the understanding of both supporters and opponents that the provision was intended to prohibit the Board's past practice of using an employer's speeches and publications concerning unions as evidence in an unfair labor practice proceeding that a subsequent employer act had an unlawful motive. *See* 90 Iowa L. Rev. at 855 n.178 (citing H.R. Conf. Rep. No. 80-510, at 45 (1947)). There is no evidence that Congress contemplated any employee right to receive anti-union information. *Id.*

<sup>76</sup> *Arroyo v. United States*, 359 U.S. 419, 425-26 (1959) (noting legislative concern with “corruption ... extortion . . . [and] abuse by union officers”).

union through a card check, an employer and union violated Section 302.<sup>77</sup> Although other courts have rejected the argument that an agreement that provides for employer neutrality and union access to employees during organizing campaigns are “things of value” for purposes of Section 302, this theory continues to threaten the ability of employers and unions to enter into neutrality agreements with confidence.<sup>78</sup>

#### d. Challenges to Voluntary Recognition Procedures

Neutrality agreements are often coupled with labor-management agreements regarding recognition procedures. Most commonly, these agreements provide that the employer will recognize the union as the collective bargaining representative upon a majority showing of support through a “card check” or through a non-Board election.<sup>79</sup>

Prior to 1947, the NLRA provided that the Board could certify unions by relying on a secret ballot election or “any other suitable method.” At that time, a commonly used “other suitable method” was “card checks,” a procedure in which a union would obtain the signature of workers on cards authorizing the union to represent the employees. In 1947, the Labor-Management Relations Act amendments to the NLRA were passed and changed Section 9(c) to provide that secret ballot elections were the exclusive means by which a union could obtain Board certification as the collective bargaining agent for a group of employees. However, even after these amendments, the Board continued to recognize that card check agreements were a valid means of recognizing a union without

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<sup>77</sup> *Adcock, et al. v. UAW, et al.*, Fourth Cir. Case No. 06-2287.

<sup>78</sup> See *Hotel Employees Union, Local 57 v. Sage Hospitality Resources, LLC*, 390 F.3d 206, 219 (3d Cir. 2004), *cert. denied* 125 S.Ct. 1944 (2005) (finding that such a theory of Section 302 is “remarkable” and “makes no sense”); *Patterson v. Heartland*, 428 F.Supp.2d 714, 724 (N.D. Ohio 2006).

<sup>79</sup> See 55 *Indus. & Lab. Rel. Rev.* at 46-47.

certification (“voluntary recognition”) as the collective bargaining representative for employees.

Although the Board and the courts have long held that voluntary recognition is lawful, the Board recently cast doubt on how recognition agreements will be treated under the NLRA. In *Dana Corp.*, the Board decided to craft a special rule for unions that had been recognized through non-Board procedures, including through card-checks.<sup>80</sup> The Board held that it would not apply the traditional “recognition bar” to a situation where the union had not been certified by a Board election. Under the Board’s previous decisions, an employer’s recognition of a union in good faith and based on a demonstrated and verified majority status would immediately bar an election petition filed by an employee or a rival union for a reasonable period of time. However, in *Dana*, the Board concluded that, in the absence of a Board-conducted election, “the immediate post-recognition imposition of an election bar does not give sufficient weight to the protection of the statutory rights of affected employees to exercise their choice on collective-bargaining representation through the preferred method of a Board-conducted election.”<sup>81</sup>

The majority opinion in *Dana Corp.* asserted that the Board was not “question[ing] the legality of voluntary recognition agreements based on a union’s showing of majority support,” and reaffirmed that voluntary recognition is “undisputedly lawful” under the NLRA.<sup>82</sup> The decision also expressly did not address “the legality of

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<sup>80</sup> 351 N.L.R.B. No. 28, slip op. at 1-2 (2007).

<sup>81</sup> *Id.* at 1. The decision held that no election bar will be imposed after a card-based recognition unless (1) employees in the bargaining unit receive notice of the recognition and of their right, within 45 days of the notice, to file a decertification petition or to support the filing of a petition by a rival union, and (2) 45 days pass from the date of notice without the filing of a valid petition. *Id.*

<sup>82</sup> *Id.* at 3.

card-check and/or neutrality agreements preceding recognition.”<sup>83</sup> However, as the dissenting Board members explained, by subjecting a union that has been recognized through a card-check or other non-Board procedure to a “window period” during which an antiunion minority of employees may file decertification petitions, the decision in *Dana* necessarily “implies that employees need an antiunion campaign in order to exercise free choice.”<sup>84</sup> Further, it “undercuts the process of voluntary recognition as a legitimate mechanism for implementing employee free choice and promoting the practice of collective bargaining.”<sup>85</sup> Moreover, it does so “at a critical time in the history of [the NLRA], when labor unions have increasingly turned away from the Board’s election process – frustrated with its delays and the opportunities it provides for employer coercion – and have instead sought alternative mechanisms for establishing the right to represent employees.”<sup>86</sup>

Thus, although the NLRA does not necessarily outlaw the collaborative approach embodied by neutrality and card-check agreements, the Board has signalled that it will be hostile to organizing and recognition procedures other than a Board-conducted election.

## 2. Challenges to Contract Negotiation under Current Labor Law

### a. Negotiating a Contract Before Recognition

In the course of negotiating the terms of a neutrality agreement and voluntary recognition agreement, employers and unions may wish also to discuss terms of a collective bargaining agreement. However, under current Board precedent, this is prohibited.

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<sup>83</sup> *Id.*

<sup>84</sup> *Id.* at 16 (dissenting opinion by Members Liebman and Walsh).

<sup>85</sup> *Id.* at 12.

<sup>86</sup> *Id.* at 12 (citing Brudney, *Neutrality Agreements and Card Check Recognition: Prospects for Changing Paradigms*, 90 Iowa L. Rev. 819 (2005)).

Section 9(a) of the NLRA provides that an exclusive representative of employees is one that is “designated or selected for the purposes of collective bargaining by the majority of the employees in a unit appropriate for such purposes. . . .” 29 U.S.C. §159(a). In *International Ladies’ Garment Workers’ Union v. NLRB (Bernhard-Altman Texas Corp.)*, the Supreme Court relied on Section 9(a) to hold that an employer improperly recognized a labor union as the exclusive representative of its employees at a time when the union was supported by only a minority of the employees.<sup>87</sup> In interpreting Section 9(a), the Court suggested that a premature contractual agreement between the employer and union might provide a “deceptive cloak of authority with which [the union could] persuasively elicit additional employee support.”<sup>88</sup>

In *Majestic Weaving*, the NLRB, applying Section 8(a)(2) of the NLRA, extended the reasoning of *Bernhard-Altman* to prohibit a union and employer from negotiating terms of a collective bargaining agreement before the union has been recognized as the employees’ exclusive representative, even though in that case the execution of the collective bargaining agreement was “conditioned . . . on the [union] achieving a majority at the ‘conclusion’ of negotiations....”<sup>89</sup> The Board reasoned that “contract negotiation following an oral recognition agreement” constituted a “premature[] grant[]” of exclusive bargaining status, just as much as did the interim agreement in *Bernhard-Altman*.<sup>90</sup>

Thus, an employer and union generally are forbidden from negotiating an agreement that would establish wages, fringe benefits, and other terms and conditions of employment before the union receives the support of a majority of bargaining unit

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<sup>87</sup> 366 U.S. 731, 737 (1961).

<sup>88</sup> 366 U.S. at 737.

<sup>89</sup> *Majestic Weaving Co., Inc. of New York*, 147 N.L.R.B. 859, 860 (1964).

<sup>90</sup> 147 N.L.R.B. at 860.

employees.<sup>91</sup> This restriction means that in the course of negotiating a neutrality and/or card check agreement, an employer and union may not agree to certain terms and conditions of a model contract that would apply if and when the union were to demonstrate majority support – something all parties, including the employees deciding whether to support the union as their bargaining representative, might benefit from knowing in advance.

#### b. Applying the Terms of an Agreement to Other Units

Another issue that frequently arises in bargaining is the desire to have a clause that extends the terms of the collective bargaining agreement to other facilities maintained by the employer. Under the Board’s 1975 decision in *Kroger Co.*, an employer and union may agree to apply the terms of an existing contract to later-acquired bargaining units or to an expanded bargaining unit.<sup>92</sup> The Board has recognized that such provisions often “protect[] the jobs and work standards of bargaining unit employees . . . by removing economic incentives which might otherwise encourage [the employer] to transfer such work to other [facilities] under its control.”<sup>93</sup>

However, unless a healthcare employer and union have a pre-existing collective bargaining relationship in at least one unit, their ability to negotiate a “master” contract for more than one facility at a time is constrained by the doctrine set forth in *Majestic Weaving*. And, in negotiating a neutrality agreement regarding organizing procedures, an

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<sup>91</sup> The NLRA provides an exception to this general rule for the construction industry. See [redacted].

<sup>92</sup> *Kroger Co.*, 219 N.L.R.B. 388, 389 (1975)

<sup>93</sup> *Lone Star Steel*, 231 NLRB at 576. See also [redacted] *Pall Corp. v. NLRB*, 275 F.3d 116, 122 (D.C. Cir. 2002) (“[a]n agreement providing for a CBA automatically to extend to employees in a new facility . . . is indeed a ‘direct frontal attack’ upon the issue of work being transferred out of the bargaining unit”). However, a contract provision that the terms and conditions of a contract will apply to employees in an expanded unit, or to additional units, may constitute a permissive subject of bargaining – and thus a provision on which a union may not insist in negotiations. *Pall Corp.*, 275 F.3d at 122.

employer and union cannot also negotiate the terms of a model contract unless the union already represents a unit of employees.

### 3. Day to Day Interactions

#### a. Section 8(a)(2) and Employee Engagement

As noted above, Section 8(a)(2) of the NLRA was written in part to overcome the abuses of company unions that predated the Wagner Act. That was a legitimate concern then and continues to be so today. However, engagement, teamwork, and coordination are important in all healthcare settings regardless of union status. The legacy of this section of labor law renders the legality of employee engagement with management in non-union or partially unionized settings is at best ambiguous and possibly illegal. While a wholesale revision of Section 8(a)(2) would not be appropriate, healthcare reform legislation should make clear that the use of collaborative working groups, which would include both employees and supervisors or managers, should not be considered a violation of Section 8(a)(2) in the absence of any evidence of employer domination. Without such a provision, efforts to encourage employee engagement and collaborative initiatives will be subject to legal attacks.

#### b. The Composition of the Bargaining Unit

A trilogy of recent decisions by the NLRB has had the effect of excluding many charge nurses from bargaining units represented by unions.<sup>94</sup> In 2006, in *Oakwood Healthcare, Inc.*, the NLRB concluded that charge nurses who assign nurses and aides to particular patients may be deemed “supervisors” under the NLRA and are thus outside

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<sup>94</sup> Prior to the decision, the Economic Policy Institute estimated that the case and two companion cases on similar issues threatened to remove 8 million workers from the protections of the NLRA. See Laura P. Juran, “NLRB’s Landmark Decisions on the Definition of ‘Supervisor’ under Federal Labor Law,” *Bender’s Cal. Labor & Employment Bull.*, Vol. 2006, No. 10-11, at 383 (Oct./Nov. 2006).

the protections of the Act.<sup>95</sup> This is true even if a charge nurse assigns other employees only for the duration of a single shift.<sup>96</sup>

The exclusion of charge nurses from bargaining units, and the ensuing controversies regarding which nurses qualify as statutory supervisors, often means that employees who take on this leadership role are not in the bargaining unit and thus are not represented by the union in negotiations. By dividing the workforce in this artificial way, this creates yet another obstacle to a collaborative approach, and any healthcare reform legislation should address this issue and allow for union representation of charge nurses.

## **B. Creating a Legal Framework that Encourages Collaboration in Healthcare**



We have identified three critical areas in which federal labor law doctrines inhibit employer-employee collaboration in healthcare facilities: first, procedures for organizing and recognizing labor organizations; second, rules governing the negotiation of labor-management agreements; and third, rules governing day to day interactions. In all three of these areas, the legal doctrines are out of synch with modern concepts of work design and organization in healthcare facilities. They often constrain worker engagement and coordination while, at the same time, providing no encouragement or support for building enduring collaborative relationships. They also provide no guidelines for holding the partners in such relationships accountable. Because collaboration between employers

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<sup>95</sup> 348 N.L.R.B. No. 37 (Sept. 29, 2006). Under the NLRA, an individual qualifies as a supervisor if he or she performs supervisory functions – such as assigning work – a “regular and substantial” amount of time. “Regular” means according to a set schedule or pattern and “substantial” means at least ten to fifteen percent of the individual’s total work time.” [This quotation mark doesn’t have a matching quotation mark.] *Id.*, slip op. at 9.

<sup>96</sup> However, in the companion case of *Golden Crest Healthcare Center*, 348 N.L.R.B. No. 39 (Sept. 29, 2006), the Board found that charge nurses who could *ask* other employees to stay late, or to work on an under-staffed floor, or to alter their workloads to balance disparities in workloads, but had no authority to *require* compliance with those requests, were not “assigning” work and thus were not supervisors for purposes of the NLRA.

and employees is critical for the success of healthcare reform, a new approach to organizing and negotiating principles is necessary.

The proposals contained in this section could be implemented by including in federal healthcare reform legislation certain labor law provisions specific to healthcare facilities, as a carve-out from the NLRA and the LMRA.<sup>97</sup>

### 1. Employer Neutrality in the Organizing and Recognition Process

Unions increasingly have turned away from Board-conducted elections as a way of organizing new facilities. As discussed above, the reasons for this are several-fold. One of the most significant reasons is the inescapable conclusion that the NLRA “fails to protect workers’ ability to choose to organize and bargain collectively with their employers.”<sup>98</sup>

Additionally, NLRA rules governing organizing campaigns and recognition procedures “‘lock[] employers and unions into an unnecessarily adversarial posture before bargaining relationships can begin,’ and thus hinder the development among employees of the kind of ‘organizational citizenship behavior’ that [has been] show[n] to be integral to contemporary work systems.”<sup>99</sup> Indeed, the NLRB’s current policy is to avoid “‘prob[ing] into the truth or falsity of the parties’ campaign statements’ and to

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<sup>97</sup> There is a real need for federal reforms, in part because efforts by state and local governments to advocate for innovative approaches to labor-management relations consistently run into problems of federal labor law preemption. See, e.g., *Chamber of Commerce*, 128 S. Ct. 2408 [Is this the correct citation form?]; *Metropolitan Milwaukee Ass’n of Commerce v. Milwaukee County*, 431 F.3d 277 (7th Cir. 2005). Of course, federal labor preemption leaves states free to regulate union activity and labor relations of workers and employers not covered by the NLRA, such as public employees and agencies.

<sup>98</sup> Sachs, 1 Harv. L. & Pol’y Rev. at 375; see also *id.* (noting “scholarly consensus that federal labor law is not simply dysfunctional but also peculiarly resistant to the reinvention it so clearly needs”).

<sup>99</sup> *Id.* (quoting Samuel Estricher, *Freedom of Contract and Labor Law Reform: Opening Up the Possibilities for Value-Added Unionism*, 71 N.Y.U. L. Rev. 827, 835 (1996); and Katherine V. W. Stone, *From Widgets to Digits: Employment Regulation for the Changing Workplace* (2004) at 94-99).

leave election results undisturbed despite the widespread use of ‘misleading’ speech.”<sup>100</sup> Similarly, the Board permits employers to engage in “captive audience” meetings with workers and to convey anti-union sentiments to employees in other coercive forms.

These policies mean that election campaigns are often marked by vicious rhetoric by both sides and a variety of tactics designed to undermine the credibility of the parties. The result of such acrimonious election campaigns often is a deep and lasting distrust among the parties, which is not conducive to productive bargaining relationships.

That many unions have turned to neutrality agreements as a better way of organizing employees does not mean that the path to a neutrality agreement is without workplace controversy. Indeed, many union organizing campaigns are forced to devote significant time and resources to obtain neutrality agreements from employers. These campaigns can involve tactics that are as acrimonious and confrontational as those involved in traditional election campaigns, even though the parties may ultimately reach a neutrality agreement. Although better than a bitter election campaign, such pre-neutrality agreement campaigns can result in lingering hard feelings and distrust and may jeopardize the future ability of employees to participate in collaborative structures in a meaningful and productive way.

Therefore, it is imperative that a federal labor policy consistent with meaningful healthcare reform ensure that employees are able to communicate freely among themselves and with representatives of labor organizations about the advantages and disadvantages of unionization, without fear of discipline or retaliation from their employers. In particular, three key elements will promote the ability of employees to

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<sup>100</sup> Sachs, 1 Harv. L. & Pol’y Rev. at n.36 (quoting *Midland Nat’l Life Ins. Co.*, 263 N.L.R.B. 127, 133 (1982)).

make uncoerced and informed decisions about unionization: (1) employer neutrality, including providing union access to employees; (2) recognition equivalent to Board certification based on card checks; and (3) the ability to negotiate a tentative first contract or a contractual framework prior to a card check. These three touchstone elements will lead to relatively short-term organizing campaigns in which the employer, the employees, and the union will all have knowledge of the prospective contract terms, and will result in the question of representation being resolved quickly and without negative and destructive campaigning by the employer and union. Such new legislation should also make clear that voluntary labor-management agreements are encouraged, and that agreements to abide by negotiated organizing and recognition procedures do not constitute unlawful employer assistance (unless employer domination is shown), nor do they give rise to liability under Section 302 of the LMRA.

a. Employer Neutrality and Union Access.

A new healthcare labor law should require employers to remain neutral during union organizing campaigns and to provide union organizers with reasonable access to the healthcare facilities.

An employer neutrality requirement would raise considerable First Amendment concerns. However, there are two primary arguments that may be made in defense of this requirement. First, the requirement of union neutrality is necessary and germane to achieving Congress' purpose of improving the quality of healthcare delivery and its interests in ensuring that employees are able to select bargaining representatives without undue coercion or pressure from the employer.<sup>101</sup> Second, Congress could make the

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<sup>101</sup> This argument would be based on *Abood v. Detroit Board of Education*, 431 U.S. 209 (1977), and its progeny, which hold that certain infringements on First Amendment rights may be justified where they are

neutrality requirement a condition of receiving federal funds, and defend the requirement on the basis that with respect to its own programs, Congress may adopt rules to promote collaboration and a non-adversarial environment to ensure quality healthcare delivery systems.<sup>102</sup> Because these two arguments in defense of the neutrality requirement are not mutually exclusive, and because neither is a guaranteed defense against a First Amendment challenge, it makes sense to frame healthcare labor law reforms in such a way as to benefit from both arguments. This means that the employer neutrality requirement should be imposed on all healthcare employers that receive federal funds.

The neutrality requirement itself should mandate that healthcare employers maintain “neutrality” regarding to efforts to organize their workers. In theory, “neutrality” could be defined in one of two ways: that the employer may not oppose or support unionization efforts; or that an employer may not oppose unionization, but may speak in favor of unionization. The justification for employer neutrality – under both available constitutional defenses – would rest on the notion that Congress’ interests in promoting delivery of quality healthcare services are furthered by a non-adversarial, collaborative work environment where employees are able freely to choose their bargaining representatives, and that such an environment does not exist when employers are allowed to oppose union organizing campaigns. Thus, under this rationale, a “neutrality” requirement might permit employer speech in favor of unionization. But


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“germane” to achieving an important governmental interest. It would also rely on cases such as *NLRB v. Gissel Packing Co.*, 395 U.S. 575 (1969), for the proposition that employer speech to workers during an organizing campaign can be regulated because it is not public discourse and because such regulation is necessary to protect the associational rights of employees.

<sup>102</sup> This argument would be based on cases holding that Congress constitutionally may impose restrictions on federal funds to ensure that federal funds are “spent for the purposes for which they [a]re authorized,” even if doing so forbids the use of government funds on certain speech.” **[This quotation mark doesn’t have a matching quotation mark.]** *Sullivan v. Rust*, 500 U.S. 173, 196 (1991); *see also Regan v. Taxation with Representation*, 461 U.S. 540, 549 (1983).

such a definition may be viewed as an attempt by Congress to suppress “ideas thought inimical to the Government’s own interest,”<sup>103</sup> and thus raise additional constitutional concerns that a definition of employer neutrality as mandating employer silence is not as likely to raise. Therefore, the neutrality requirement should simply prohibit employers from speaking with employees about an ongoing union organizing campaign.

The employer neutrality requirement should also identify particular employer practices that will be deemed non-neutral employer interference with union organizing activity, including:

1. Holding “captive audience” meetings or other mandatory meetings with the purpose of influencing workers’ views about union formation;
-  2. Engaging in one-on-one or group conversations or communications with workers with the purpose of influencing their views about union formation;
3. Requiring workers to watch videos designed to influence their views about union formation;
4. Conducting training or orientation sessions for workers or management with the purpose of influencing their views about union formation;
5. Distributing materials designed to influence workers’ views about union formation or confiscating pro-union materials;
6. Suggesting or implying that workers will lose benefits, wages, or otherwise enjoy less favorable working conditions if they select union representation;
7. Retaliating or threatening to retaliate against workers for engaging in or supporting union activity;

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<sup>103</sup> *Legal Servs. Corp. v. Velazquez*, 531 U.S. 533, 548-49 (2001).

8. Harassing, intimidating, or otherwise discriminating against union members or supporters.<sup>104</sup>

The two constitutional defenses of the neutrality requirement – the argument that Congress may impinge on fundamental rights in order to achieve an important governmental interest, and the argument that Congress may choose to encourage “certain activities it believes to be in the public interest,” even if doing so may result in the funding of some speech to the exclusion of other speech<sup>105</sup> – are marked by similar vulnerabilities that should be addressed in the legislation. Specifically, the fact that the employer neutrality requirement would essentially act as a blanket prohibition on speech about unionization during organizing campaigns raises questions under both defenses regarding the extent of the infringement on employers’ free speech rights.<sup>106</sup> Thus, the legislation should stress that the restriction of employer speech is the minimum restriction necessary to achieve Congress’ goals in improving healthcare quality. Additionally, the legislation should make clear that the employer neutrality requirement applies only in the context of an organizing campaign, and thus does not prohibit the employer from speaking against (or in favor) of unions at other times. Finally, it is imperative that the

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<sup>104</sup> Under Section 8(a) of the NLRA, these last two provisions constitute prohibited unfair labor practices. The Employee Free Choice Act (EFCA), if enacted, would also impose additional penalties on employers for engaging in such unfair labor practice charges during an organizing or first contract campaign.

<sup>105</sup> *Sullivan v. Rust*, 500 U.S. 173, 193 (1991); *id.* at 194 (holding that it was not unconstitutional for the federal government to “choose[]to fund a program dedicated to advance certain permissible goals, because the program in advancing those goals necessarily discourages alternative goals”); *see also Lyng v. Int’l Union, UAW*, 485 U.S. 360, 368-69 (1988) (denying benefits to households with striking workers simply represented the legislature’s decision not to subsidize the exercise of a fundamental right and was not unconstitutional).

<sup>106</sup> Under the *Abod* line of defense, this is an issue because existing precedent has focused on compelled association and compelled speech that has nonetheless left the objecting party free to express an alternative perspective. *See, e.g., Glickman v. Wileman Bros. & Elliot, Inc.*, 521 U.S. 457, 469 (1997) (stressing that the challenged marketing orders for fruit tree producers “impose[d] no restraint on the freedom of any producer to communicate any message to any audience”). Under the “government funding” line of defense, this is an issue because, even though the precedent suggests that a recipient of government funds can either decline the funds or establish a new entity if the recipient wants to engage in the prohibited speech (*Rust*, 500 U.S. at 198), the cases nonetheless consider whether, “with respect to the . . . services Congress . . . funded, there [are] alternative channel[s] for expression of the advocacy Congress seeks to restrict.” *Legal Servs. Corp. v. Velazquez*, 531 U.S. 533, 546-47 (2001).

legislation in no way suggest that Congress' goal in instituting the neutrality requirement is to regulate employers' speech; instead, Congress' decision should be based on its desire to improve the quality of healthcare delivery by using collaborative approaches in the workplaces, and on findings that such improvements are not possible without limiting employer speech during organizing drives.

The requirement of employer neutrality should also be coupled with a requirement that healthcare facilities provide certain access rights to labor organizations during organizing campaigns. Allowing employees to meet with union representatives at the workplace further encourages employees to be engaged and eliminates a frequent source of tension between employers, unions, and employees during organizing campaigns.

Congress may make the grant of such access a condition of federal funding. Because an access requirement does not regulate or infringe on speech, but rather dictates conduct, it does not raise the same constitutional concerns as the neutrality requirement does. Indeed, the Supreme Court recently upheld the constitutionality of the Solomon Act, which required law schools receiving federal funds to grant access to military representatives for recruiting purposes.<sup>107</sup> The Court explained that the Solomon Amendment “regulate[d] conduct, not speech,” “affect[ing] what law schools must *do* – afford equal access to military recruiters – not what they may or may not *say*,”<sup>108</sup> and that any incidental burden on the law schools' speech was permissible because it effectively promoted a substantial governmental interest.<sup>109</sup>

#### **b. Recognition Procedures**

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<sup>107</sup> *Rumsfeld v. Forum for Academic and Institutional Rights, Inc.*, 547 U.S. 47 (2006).

<sup>108</sup> *Id.* at 60 (emphasis in original).

<sup>109</sup> *Id.* at 53, 67.

Additionally, health care institutions receiving federal funds should be required to recognize a labor organization that demonstrates majority support through a card check. The currently proposed Employee Free Choice Act (“EFCA”) provides a model for such procedures.<sup>110</sup> The EFCA provides that, “[i]f the Board finds that a majority of the employees in a unit appropriate for bargaining has signed valid authorizations designating . . . their bargaining representative and that no other individual or labor organization is currently certified or recognized as the exclusive representative of any of the employees in the unit, the Board shall not direct an election but shall certify the individual or labor organization as the representative. . . .”<sup>111</sup> The EFCA further directs the Board to develop procedures to be used “to establish the validity of signed authorizations designating bargaining representatives.”<sup>112</sup>

Similarly, labor law reform in the context of a new healthcare policy should require employers receiving federal funds to recognize a labor organization where a majority of employees in the proposed unit has signed valid authorizations designating the labor organization as the collective bargaining representative and no other organization is currently recognized or certified as the exclusive bargaining representative.<sup>113</sup>

### c. Pre-Recognition Bargaining

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<sup>110</sup> H.R. 800 (110th Cong. 2007). Because the EFCA, as currently proposed, would amend the NLRA, it would affect only employees covered by the NLRA, and would not, for example, apply to public employees working in healthcare institutions.

<sup>111</sup> EFCA, Sec. 2(a) (proposing amendment of Section 9(c) of the NLRA).

<sup>112</sup> *Id.*

<sup>113</sup> The reforms should require employer neutrality even in the event that more than one labor union seeks to represent the employees. However, in such circumstances, a card check may not be feasible, and the resolution of the representation issue may require a Board election.

A new healthcare labor law should permit unions and employers to negotiate and publicize the proposed terms of a first contract or to agree to a framework for a contract and then to mandatory arbitration. However, such a contract would be effective only upon a showing of majority support and recognition of the union as the employees' exclusive bargaining representative. This would be a departure from the rule articulated in *Majestic Weaving* and suggested by *Bernhard-Altman*.

*Bernhard-Altman* suggests that a collective bargaining agreement negotiated before a union has established majority support provides a "deceptive cloak of authority" that may permit the union to "elicit additional employee support." But this reasoning is based on the unsupported premise that an employee's right freely to choose a representative is furthered by not knowing what terms and conditions the representative may be able to negotiate with the employer. While there is a legitimate concern that an employer and union could negotiate a "sweetheart" deal, a more effective way of protecting employee choice is to allow the terms of any deal to be publicized, discussed and debated by the employees *before* the employees decide whether to provide their support to the labor union. Additionally, permitting pre-recognition negotiations will mean that management will be better able to predict what will happen if the employees unionize and, where employees choose to be represented, will lead to less uncertainty in the workplace in the time period following recognition.

#### d. Voluntary Labor-Management Agreements

Finally, as a general matter, employers and unions should be free to agree to principles beyond the baseline requirements of employer neutrality, access, and recognition based on card checks. For example, if an employer wants to provide a union

or unions with heightened access to its premises, beyond what is required by the proposed reforms, nothing should prevent the employer from doing so. However, as described in Part IV.A.1 above, such voluntary agreements have been challenged as illegal.

Accordingly, a new federal healthcare labor law should also make clear that voluntary agreements between employers and unions regarding organizing and recognition procedures are encouraged and are not unlawful. Further, there should be a specific statement in the new legislation clarifying what everyone has always understood to be the law – that a voluntary agreement providing for neutrality, access, employee lists, and labor-management cooperation, does not constitute a “thing of value” for purposes of LMRA Section 302 and may not form the basis of a violation of that section. Similarly, the legislation should make clear that an employer does not unlawfully interfere with or dominate a labor union, and thereby violate Section 8(a)(2) of the NLRA, simply by agreeing to remain neutral during an organizing campaign or by providing union organizers access to its facilities.

## 2. Encouraging Collaboration in the Negotiation Process

Healthcare reform legislation should encourage collaboration in the negotiation of collective bargaining agreements and assist parties in negotiating first contracts expeditiously.

### a. Procedures For Contract Negotiations.

The NLRA assumes that adversarial bargaining motivated by the threat of a work stoppage will produce an orderly process and results that are in the best interests of workers and employers. However, modern tools of negotiation can encourage healthcare

workers to collaborate in a way that generates solutions to workforce, patient, and management concerns, without relying on the often unsuccessful bargaining models set forth in the NLRA.

In particular, reforms to healthcare labor law should provide procedures for negotiation of first contracts in those circumstances where no pre-recognition agreement has been reached. The EFCA is a good first step toward such procedures. It provides that, whenever parties are negotiating an initial agreement following certification or recognition, if no contract is reached after 90 days of bargaining, either party may request mediation services from the Federal Mediation and Conciliation Service (“FMCS”). Further, if mediation is unsuccessful after 30 days (or any additional period agreed upon by the parties), FMCS must refer the matter to arbitration. The arbitration panel will then render a decision setting the terms of the contract that will be binding on the parties for the next two years, unless the contract is amended by the parties during that time. The EFCA requires mandatory arbitration only of first contracts and does not apply to subsequent negotiations for successor agreements. In contrast, specific healthcare reform legislation could include an extension of the EFCA procedures to provide for mandatory arbitration of all collective bargaining agreements when the parties are unable to negotiate or mediate a deal.

Providing for mandatory arbitration will assist in creating and maintaining a collaborative work environment. It may also remove some of the barriers to collaboration that are created by the somewhat arbitrary distinction between mandatory and permissive subjects of bargaining under the NLRA. Because the NLRA assumes that negotiations should focus on specified wages, hours, and working conditions and allows

unions to insist only on these matters, unions may have little bargaining strength on issues critical to the goals of improving healthcare delivery, such as quality improvement and cost controls, design and utilization of medical information technologies, work system design, and workforce scheduling and utilization. Requiring mandatory arbitration of all issues raised by the parties would ensure that a first contract addresses these important issues.

b. Application of Contract to Newly Organized Facilities

Under current federal labor law, the ability of employers and unions to agree to apply the terms of a model or master contract to multiple facilities may be restricted by concerns regarding the specific bargaining unit for which that contract was initially negotiated, when the contract was negotiated relative to the recognition process, and whether the contract calls for an expanding bargaining unit or for multiple units. As discussed above in the proposal to dispose of the *Majestic Weaving* doctrine, permitting newly organized employees to know the potential terms of a collective bargaining agreement *before* they vote on whether to authorize the union as their representative promotes informed decision-making. It also promotes a more collaborative negotiation process that is less likely to be subject to surprises and stalemate situations.

In the healthcare sector, work is often transferred between hospitals and employees may work in one or multiple facilities. Additionally, the working conditions in one facility may be influenced by economic and personnel decisions made at other facilities managed by the same employer or in the same general market. Therefore, a labor-management agreement should be permitted to cover working conditions in multiple facilities without requiring re-negotiation of the agreement – provided the

application of the contract (and recognition of the union as the employees' exclusive bargaining representative) is conditioned on a showing of majority support.

### 3. Supporting Accountability in Labor-Management Cooperation

A modern healthcare labor law should encourage and support labor-management partnerships capable of building and sustaining collaborative work environments among healthcare workers, managers, and physicians. At a minimum, obstacles to cooperation in current labor law should be eliminated. This would start with the reversal of recent National Labor Relations Board and Supreme Court decisions that take away the rights of union membership for charge nurses, for example, or other professionals who now assume some of the duties and responsibilities heretofore handled by supervisors.. Doing so would not only support the diffusion of partnerships in healthcare, it would be an important step toward updating labor law doctrines to match accepted ways of organizing and carrying out work in today's organizations.

But a more fundamental restatement of the underlying goal of labor law is needed to overcome the traditional assumption that labor-management relations are inherently adversarial in nature. Labor relations in America suffer from a self-fulfilling prophecy: the relationship between labor and management will inevitably be adversarial if the doctrines underpinning labor law assume them to be so. If, however, the underlying goal of labor policy in general, and labor law in particular, is restated as implementing the fundamental right of freedom of association so as to promote the public interest in achieving productive, high quality delivery of healthcare, it become clear that the alternative legal rules and doctrines discussed in this report are needed to break out of the self-fulfilling prophecy in current law.

More broadly, those who lead labor policy should no longer be agnostic about the shape and character of labor relations practice. In recent years, policy makers have largely taken a hands-off or even hostile approach to labor and management practice or issued regulatory decisions that set practice back. This was not always the case. As long ago as World War II, government leaders recognized the value of helping labor and management implement and institutionalize innovations, such as grievance procedures, wage and salary standards that achieved equity without inflating prices, private pensions and health insurance, and joint safety and productivity committees. Those innovations were deemed to be essential for meeting the challenges of their day. In the decades following the War, similar leadership ensured that peaceful labor relations developed and were maintained in critical industries and installations dealing with atomic energy and space exploration, in the postal service, and in specific negotiations where national health or safety were at risk. In 1978, Congress took the affirmative step of enacting the Labor Management Cooperation Act to provide funds for promoting joint efforts to improve labor-management relations.

The vision and leadership behind such initiatives are now absent at the highest levels of labor relations policy-making and administration. A return to the type of policy leadership once present in government would clearly allow and encourage labor-management partnerships to be put to use in pursuit of these goals and would create an environment in which collaboration would no longer be so precarious. With this type of leadership, partnership might just evolve to become standard labor relations practice.

### **Summary – Proposed Healthcare Labor Relations Act**

The objectives of the new Healthcare Labor Relations Act proposed here are to:




- Support the nation’s efforts to expand access to and improve the delivery of healthcare services by building a highly skilled, fully engaged, and fairly compensated healthcare workforce.
- Ensure that the healthcare workforce and healthcare providers work in partnership to deploy state-of-the art medical technologies, organize work to promote teamwork, coordination, and continuous improvement in the delivery of healthcare, and build labor-management relationships based on trust and mutual respect among healthcare employees, managers, and physicians.

As described above, the legislation’s specific provisions should include the following:

1. Recipients of federal funding are required to remain neutral during union organizing campaigns and must recognize a union on the basis of a card check.<sup>114</sup>
2. Recipients of federal funding are required to provide access rights to labor organizations during organizing campaigns.
3. Voluntary agreements regarding other organizing and recognition procedures are encouraged and are not unlawful under Section 8(a)(2) of the NLRA or Section 302 of the LMRA.
4. Labor organizations and management are permitted to negotiate the terms of a first contract, or a framework for a first contract, prior to recognition of a labor organization as the exclusive collective bargaining representative; provided, that the contract is not effective unless and until the labor organization demonstrates majority support.
5. Provision for mediation and arbitration in negotiations where the parties fail to reach agreements on their own within specified periods of time.
6. A labor-management agreement may lawfully provide that the agreement will cover working conditions in multiple facilities provided the union demonstrates majority support in the covered facilities.
7. Elimination of the management-nonmanagement or supervisor doctrines that currently prohibit union representation for charge nurses and others who carry out minimal supervisory duties.
8. Support for development of collaboration, teamwork and labor-management partnerships.

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<sup>114</sup> As discussed above, an alternative would be to prohibit recipients of federal funding from using federal money to oppose (or support) union organizing campaigns. 

9. Affirmation that participation of nonunion employees in collaborative panels or other forms of engagement with management is permissible provided these do not interfere with employee efforts to form independent unions or constitute company sponsored labor organizations.



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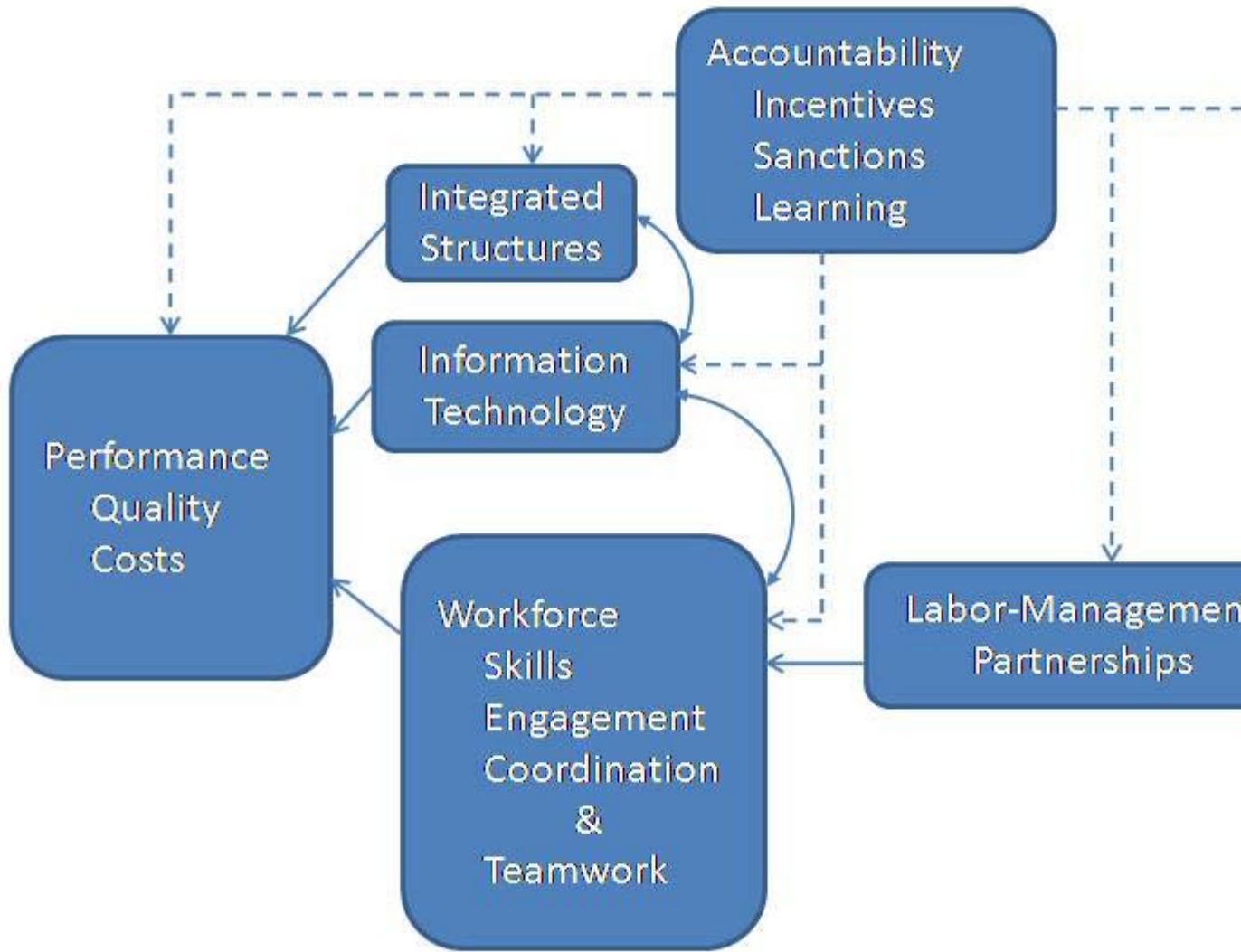
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# Integrated Health Care Model



# Integrated Health Care Model

