# The Challenge to Change

## *Reforming Health Care on the Front Line in the United States and the United Kingdom*

Rebecca Kolins Givan

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# Introduction

On the eightieth anniversary of the British National Health Service (NHS), US physician Don Berwick, an unabashed fan, gave a speech expressing his great love for the NHS. "There comes a time, and the time has come," he said, "for stability, on the basis of which, paradoxically, productive change becomes easier and faster, as the good, smart, committed people of the NHS—the one million wonderful people who can carry you into the future—find the confidence to try improvements without fearing the next earthquake" (Berwick 2008). In the same speech Berwick lamented the US health care system, which he characterized as a "duplicative, supply-driven, fragmented care system" (Berwick 2008). This book examines the tension between productive improvements and unproductive "earthquakes" in both the United States and the United Kingdom. This tension is, indeed, the core problem for anyone hoping to improve health care quality anywhere.

For over a decade I have listened intently as workers and managers have described the myriad new initiatives pouring down upon them, constantly interrupting their ability to provide high quality and appropriate health care.

Policymakers routinely believe they have found a panacea—a single change that will dramatically improve health care outcomes, lower costs, or even do both. As one frustrated hospital manager told me when I asked if he was adequately consulted over new initiatives, "they do consult us; it's not clear whether they ever listen to the answers" (personal interview, March 28, 2002). This sentiment was echoed by scores of frontline workers and their managers over my years of research in hospitals in two countries, demonstrating the true challenge of implementing worthwhile change in hospitals.

In the United States and United Kingdom, health care workers, tiring of constant attempts to improve efficiency or measure performance, are complaining about their great weariness with change, sometimes known as change fatigue. In this book I examine how health care change has been implemented in hospitals in these two countries and historically what factors have combined to make meaningful, lasting change. Hospitals are the site of the preponderance of health care delivery (whether measured in patient acuity, employment, or expenditures), and they are also the most complex, sophisticated organizations in the health care sector.

Health care payers, regulatory bodies, and policymakers send initiative after initiative into the workplace, where frontline staff struggle with the constant dilemma of how to care for their patients while simultaneously pursuing initiatives that have come from outside their organizations. The push from policymakers, executives, and insurers for transformation, change, and reform in health care delivery is incessant (Berwick 2008). Private organizations, politicians, and regulators continue to push to improve performance, reduce waste, and spread best practices in hospitals. Health care providers are being encouraged or required by payers and regulators to do more with less. To comply with the onslaught of new rules and regulations, providers are expected to implement massive new information technology systems that will digitize service delivery and medical records, reduce medical errors, and make health care more patient-centered. At the same time, hospitals on both sides of the Atlantic have been required to measure everything they do and to demonstrate their high level of performance (Bevan and Hood 2006; Chassin et al. 2010).

Although health care leaders and managers around the world have been constantly preoccupied with productivity and performance, they also have a newer concern. Between 1999 and 2000, influential reports in both the United States and the United Kingdom highlighted the startling cost in

human life as well as money of medical errors (Department of Health 2000, 2001; Gaffney et al. 1999; Kohn, Corrigan, and Donaldson 2000). In the United States, for example, an influential Institute of Medicine report estimated that 98,000 deaths were caused by medical errors each year, but more recent estimates suggest the figure may be as high as 400,000 deaths per year (James 2013; Kohn, Corrigan, and Donaldson 2000). Groups such as the Institute for Health Care Improvement in the United States and the National Patient Safety Agency in the United Kingdom, among many others, began to push for patient safety around the year 2000. Recent research suggests that the problem is still quite serious and that morbidity and mortality resulting from medical errors may be at far higher levels than even the earlier, attention-getting estimates (James 2013). Most of the patient-safety initiatives have been accompanied by the introduction of new technologies such as electronic medical records. Thus, payers and policymakers ask managers and frontline staff to master new computer systems, which may have their own pitfalls and introduce threats to patient safety (Koppel et al. 2005). Hospital workers and managers have therefore had to contend with yet another series of change initiatives and scoring mandates, with an attendant set of penalties for noncompliance.

Numerous public and private organizations, including the Institute for Healthcare Improvement and the Joint Commission in the United States, and the National Institute for Clinical Excellence and Dr. Foster Intelligence (an independent, university-based research body), have launched dozens of programs spotlighting the need for everything from hand-washing to team communication. Many of these vaunted programs, such as the Six Sigma Black Belt, engage only the top managers and lead physicians in a hospital and leave the key issue of staff engagement to chance (Dunn 2014). Managers and staff are somehow expected to incorporate these new initiatives into their practices while also dealing with a labor shortage in most of the skilled professions and higher demands from an aging population and improved medical technologies.

From metric-driven performance monitoring to the patient-safety movement, the only constant is change. Civil servants, researchers, and consultants craft and bring into the hospitals a cascade of change and reform initiatives with no clear rationale, and they ask managers, professionals, and other workers to accept and implement these new ideas. These initiatives often rely on highly paid external consultants to implement programs such

as lean production, Six Sigma, and Hardwiring Excellence to reengineer work processes, frequently from the top down, relying on approaches imposed by outsiders without frontline experience (Vest and Gamm 2009). In spite of change fatigue and skepticism from workers about the results of initiatives that have been launched only to fail, managers and professionals seemingly face no choice but to accept, adopt, implement, and adapt these initiatives.

Enormous amounts of time, money, and energy are devoted to this process of implementation, adaptation, and acceptance. Hospital managers and staff are frequently held accountable for the successful implementation of these initiatives. At the top of the health care hierarchy, policymakers and consultants make sweeping promises about the benefits of their change initiatives. As they throw around concepts such as streamlining, efficiency, quality, and excellence, they have created a whole new health care jargon equipped with "pillars" and "belts" and lean production processes. They argue that these will produce better health outcomes at lower cost and will provide patient-centered care with greater patient satisfaction. Frontline staff—whether management, professionals, or support staff—seem to have little choice but to acquiesce to these initiatives. But they often find it difficult to initiate their own changes.

## Critical Questions

What are the results of all these promises, time, and money? Do big ideas from outside the hospitals improve health care outcomes? Is change best when it is imposed from above? Does the relentless quest for change produce better patient care, greater efficiencies in health care, quality services, or even dramatic cost savings? If not, what are the results of these initiatives? When do they prompt acceptance and when do they provoke resistance? How do the organization of the workplace and its complex relationships influence the acceptance of change imposed from the outside? When and how do managers and professionals try to shape these programs to suit their own and their patients' needs? Do they succeed? Or is what results a constant series of compromises and adaptations to adaptations? When does change move from the macro to the micro, and when is the opposite true?

Over the past two decades, my work has been devoted to the health care systems in both the United States and the United Kingdom. As a long-term resident at various times and a citizen of both countries, I have become a keen observer and analyst of the evolving health care system in each. In this book I try to answer the critical questions I have just posed by examining a series of change initiatives as they are experienced at the front line in what appear to be two entirely dissimilar health care systems—the largely privatized system in the United States and the highly "socialized" (publicly funded and publicly provided) system in the United Kingdom. Using concrete examples of organizational and even systemwide change in these case studies, I investigate what happens when change is initiated both from above and from below.

I have found that wherever its point of departure in the complexities of the contemporary hospital, successful organizational change requires a deep level of acceptance and commitment not only from managers but also from staff on the front line. Indeed, some of the most successful health care change initiatives have been launched at the frontline level where workers responded to serious problems they had identified and struggled to remedy them, not only in their institutions but at the national or state level. Thus, I challenge the widely accepted notion that successful change is launched from above and trickles down with my analysis of how change also trickles *up* when frontline staff launch initiatives that eventually affect national policy.

A huge proportion of the research on health care change focuses on change initiatives that are launched by elite players such as CEOs, hospital administrators, or physician pioneers, and it neglects the possibility that change can also move up from the front line (Berry and Seltman 2008; Lee 2004). The general literature on management and health care change management has devoted an enormous amount of attention to those who make sweeping promises that the latest new initiative will prove a panacea that provides both quality and efficiency without a downside. The focus is on visionary leaders and their heroic and ultimately successful struggles to transform the corporation or hospital from top down (Berwick 1996, 2003; Pronovost et al. 2006). In this literature, workers—whether physicians or janitorial staff—are depicted as being afraid of change and as obstacles whose irrational resistance to change must be overcome.

In this book, however, I offer a more nuanced account. I examine the dual dynamic of health care delivery change in detail and with balance. I show

how high-level initiatives may indeed be distorted or subverted in hospitals, but I also explore why change is often resisted at the frontline level—sometimes with good reason—and try to help readers understand which top-down changes are resisted and why, and which are accepted, adopted, and sometimes constructively adapted and why.

While I analyze worker resistance to top-down change initiatives, I look beyond this to focus as well on a dynamic that has received very little attention: how changes initiated by frontline staff may trickle up to become policy at the macro level. These policies have produced positive changes that in turn have had significant impacts on safety, performance, and productivity. I argue that nonimplementation of a policy by frontline staff, such as occurred in the subversion of performance indicators in the United Kingdom, can shape future policy in surprising ways (see chapter 3). I also show how change can be initiated by workers while they are addressing problems that management seems to ignore and are struggling to transform the workplace in ways that make health care and the hospital safer for both patients and those who care for them. This crucial work is explored in chapter 6, which examines staff-driven initiatives to create a safety culture in hospitals that benefits both patients and employees.

Where unions are present, they play a key role in the implementation or obstruction of workplace change as well as influencing the development of policies at the national level. Key contributions of the health care unions cannot be ignored. In the United Kingdom, NHS hospitals are unionized, with a number of unions representing different occupational and professional groups; in the United States, union membership varies considerably by workplace and region across the health care industry (Milkman and Luce 2014). Although many politicians view unions as obstructionist, clinging to rigid contract language, and unwilling to embrace change, the reality is quite different. Health care unions play key roles in ensuring high-quality patient care, from facilitating ongoing communication to drawing attention to immediate problems such as poor infection control and unmet patient needs. In fact, well-run local unions with talented stewards frequently initiate change that may improve performance for everyone in the hospital—patients, staff, and management alike. As the organized voice of frontline health care workers, unions are well-positioned to identify problems and to suggest solutions in the delivery of care.

I do not presume that the role of unions is monolithic. Instead, my analysis starts from the observation that unions organize the voice of their members, and in this role they may be either proponents of or impediments to change. I examine the specific work of unions where they are present (almost everywhere in the UK health economy, and only in concentrated pockets in the United States). The chapters ahead highlight several cases in which unions have facilitated positive change, and they demonstrate that the view of unions as obstacles to change is at best antiquated and is more likely simply motivated by ideology rather than experience.

## Contrasts and Commonalities

In a letter to *The Guardian* in May 2015, at a time when the NHS was a key issue in the imminent election, a group of dozens of American doctors urged the British public to proceed with caution. They affirm how much the providers in these two systems look to each other:

> There are many things the US healthcare system has to admire, such as our pioneering integrated care organizations and our world-leading medical research and high-tech rescue care. At the same time, the US is in the midst of a major healthcare reform effort that aims to bring affordability and equity to American healthcare. We caution the UK against moving in the direction of a system that has created the inequality in US that we are now working to repair. Your universal, public healthcare system is an example to the world, and something of which Britain should be proud. We urge you to preserve it. (Wang 2015)

These two countries with a common language, a common model of health care provision, and a dramatically different model of health care financing have long held an interest in each other. As both these systems contemplated changes over the last several decades, their mutual awareness of each other became evident. As privatization debates continued in the United Kingdom, observers sought evidence from the private US health care system. On the occasions that single-payer health care was discussed in recent decades in the United States, the key exemplar tended to be the United Kingdom (Light 2003). Articles with titles such as "What Are the Lessons

from the USA for Clinical Commissioning Groups in the English National Health Service?" (Ham and Zollinger-Read 2012) and "A healthy debate? The US and English Health Systems" (Thorlby 2009) cropped up across the top medical, health policy, and even news publications in the United Kingdom. When private companies were given the opportunity to bid on NHS contracts, many US-based providers saw a key opportunity for profit. When a crisis of poor-quality care and high mortality rates hit the Mid-Staffordshire health care system, the US physician Don Berwick was brought in to investigate the mess. In his letter accompanying his report to senior NHS executives and government officials, he wrote, "You are stewards of a globally important treasure: the NHS" (Berwick 2013, Annex B).

This mutual awareness has often been colored by mutual suspicion. When Simon Stevens, a Brit who had spent almost a decade working in the United States as a top executive for UnitedHealth, was appointed the chief executive of NHS England in 2013, UNISON, the major public service union, responded by saying, "We sincerely hope this is not a sign that the government wants to import America-type values into the NHS and look at ways of developing healthcare through an insurance model" (UNISON 2013). Indeed, through my ongoing research on change in the two systems, I have discovered firsthand how each system looks to the other, and I have heard countless interviewees express interest, fascination, and horror in the other country's health system.

In comparisons of health systems in developed countries, the UK and US systems frequently fall at opposite poles. For example, in the Commonwealth Fund's periodic international comparison of eleven developed countries' health care systems, the United Kingdom ranks first in eight categories as well as in overall ranking whereas the United States ranks last in four categories and dead last in overall ranking (Davis et al. 2014).

Likewise, in terms of access to and payment for medical services, the US and British health care systems probably differ the most of any two in the industrialized world. The British NHS is a massive, fairly centralized single-payer, single-provider health care system. It is financed through taxation, health care providers are public employees, and access to health care is universal. In the United States, the payers and providers are far more diverse. Although the government purchases health care for more than 100 million people (including those eligible for public programs as well as public employees), most health care is purchased by employers, with a small proportion

purchased by private individuals. Before the Affordable Care Act (ACA) of 2010, this fragmented system left about 50 million people without any access to health care except in the case of emergency, a far cry from the universal coverage of the NHS.

In terms of payment, the systems differ not only in who pays for health care but in how the payment systems operate. In the United States, the payment systems create massive profits for many of the stakeholders and also provide a system of incentives that do not necessarily align with the goals of providing widespread, high-quality, and efficient health care. The NHS has relatively simple payment systems in which most providers receive salaries and the system uses its large-scale purchasing power to negotiate prices on drugs, devices, and diagnostic equipment. The story is quite different in the United States, where the system is rife with incentives to treat more: doctors and hospitals profit by providing more treatment, regardless of the quality of care or the outcomes (Brownlee 2008). Physician and health care innovator Don Berwick has referred to the US system as "supply-driven care" (Berwick 2008). This is the opposite of the UK system, which is able to focus on a broad public health strategy, prevention, and a long-term outlook.

In spite of these differences, when one looks beyond access and payment into the health care workplaces, there are striking similarities. In hospitals in both countries, work organization is structured around strong, historically entrenched professional boundaries. The often-fraught relationship between nurses and doctors is almost perfectly mirrored by hospitals in both countries. Health care providers are subject to similar challenges, such as ever-changing treatment protocols, advances in technology, and the health care needs of an aging population. Both systems face shortages of professionals, and they rely on recruiting workers from abroad. Trends in patient care, such as the patient-safety movement, penetrate both systems, generating particular pressures on the health care providers. The US system may appear to be fragmented in terms of access and payment, but the role of putatively voluntary regulators, especially the Joint Commission, means that no hospital is immune from centrally determined requirements that range from specific treatment protocols to cleanliness standards.

In this book I address another characteristic shared by the two systems: both are subject to concerted pressure to change, and their experiences with change initiatives have telling similarities.

## Change as It Actually Happens on the Front Lines

To explore these US and UK experiences in detail, I use personal interviews as well as documentary research to focus on four historical cases from the past decade (Table 1): in the United Kingdom, the introduction of the star rating system and the advent of privatization; in the United States, regulation by the Joint Commission and the development of a safety culture. Two cases are examples of change imposed from above, and two cases examine change initiated at the front line. I have chosen each case because it represents a crucial moment in the development of the current health care system and also traces a key ongoing trend in the Anglo-American health care model: accountability, centralized regulation, privatization and resistance, and the turn to quality. These four forces are acting on both the UK and US health care systems, even while each system has a different starting point in its current institutional configuration.

The cases I present offer evidence about the front line that moves beyond stereotypes of health care workers as frightened of change or as obstacles that invariably halt promising initiatives in their tracks. I focus instead on feedback effects that are instrumental in shaping future attempts to reform and restructure hospitals. Health care workers on the front line play a crucial role in shaping change. It is essential for would-be reformers to understand how change actually works in these complex institutions if they are to assess accurately the chances for implementing change at either the macro or the micro level. Without this deeper understanding, the parade of new initiatives, never fully implemented, will doubtless continue but will rarely cause actual improvements in the delivery of health care.

**Table 1. Case studies**

| Case type | United Kingdom | United States |
|---|---|---|
| Change from above | Star rating performance measurement<br>*Accountability* | Joint Commission Accreditation<br>*Central regulation* |
| Change from below | Response to privatization<br>*Privatization and resistance* | Movement for a safety culture<br>*Quality* |

My research on these cases is primarily qualitative and uses a multistakeholder, vertical-slice approach; that is, I have attempted to interview representatives of all the key stakeholders at all levels, from policy to practice. I also rely on primary and secondary documents, including government publications and employer and union-produced materials, to construct accurate accounts that include the perspectives of all relevant stakeholders. My interviewees included frontline health care workers and managers, local, regional, and national union representatives, and bureaucrats and elected officials. Most of the interviews in the United Kingdom were conducted between 2002 and 2007, with a few later interviews in subsequent years. The US interviews were primarily conducted from 2007 to 2014. I summarize the interviews and offer select representative quotations. Most interviews were conducted individually, for thirty to ninety minutes, although there were a handful of group interviews (from a two-person interview to a ten-person focus group) and a small number of telephone interviews as well. The high-level interviewees, such as those from national regulators, were specifically selected for their expertise. The frontline interviewees were selected in hospitals that represented the diversity of hospital workplaces in each country.

These interviews, as well as extensive documentary research, make up the empirical data used throughout the book. These diverse perspectives illuminate the sometimes conflicting interests of the different stakeholders in health care. Although I have not interviewed patients for this study, the research is informed, where appropriate, by patient data, including surveys reflecting patient satisfaction as well as quantitative measures of clinical outcomes. Elsewhere in my research, I have given patient sources a great deal more emphasis (see, for example, Avgar, Givan, Liu 2011a, 2011b; Givan, Avgar, Liu 2010). Although there is occasionally patient-led change in the provision of health care, this is a rare occurrence compared with change initiated by frontline providers or national regulators.[1]

1. The best example of patient-led change is probably the change in labor and delivery practices as part of the women's movements of the 1960s and 1970s. Women wrested some control of their delivery environments from doctors, and forced doctors and hospitals to allow partners and others chosen by the birthing mother to remain in the delivery room. Expectant mothers chose hospitals that would allow them this control over their birthing environment, and this competition then drove widespread adoption of the new practice. My thanks to Ellen Berman for suggesting this example of patient-driven change in health care delivery.

## Theoretical Bases

There is a rich literature in political science, sociology, and comparative political economy on welfare state institutions and welfare state reform. Health care is a pillar of any welfare state, and it is crucial to understand the constraints on and possibilities for change in health care as part of the welfare state more broadly. By including a macro level examination of these health care systems, my analysis demonstrates the relationship between national institutions and policies and the front line of service where these policies become practice.

In terms of this research tradition there are two main reasons for comparing the health care workplace in the United States and United Kingdom. First, the research is in the tradition of "most different systems" comparison and asks why, in spite of such different national institutions, the dynamic in the health care workplace is so similar in both countries (Meckstroth 1975). If one looks only at national institutions (such as the regulatory and payment systems and the role of health insurance companies), one would not expect these workplace relationships to be similar. Rather, the national institutional settings reveal massive differences in who pays for health care and who has access to health care. But in the workplaces of the two countries there are striking similarities. In particular, the relationships between professional and occupational groups, the competing needs of (and incentives for) different stakeholders, and the shortage of skilled health care professionals in the workforce (exacerbated by major retention problems) combine to create health care workplaces that bear more than a family resemblance. Health care providers in the United Kingdom and the United States have also faced similar imperatives for increased productivity and enhanced performance, as calculated using a range of sometimes controversial measures. These pressures emanate from national bodies: in the United Kingdom there is a centralized regulatory system; in the United States a series of overlapping voluntary and mandatory regulatory bodies create a kind of de facto national regulation. These similar trends in the face of systemic differences require a deeper analysis, focused at the front line of health care, the workplace.

The second reason for comparing a sector across Britain and the United States is that the economies of these two countries have been grouped together by scholars eager to create simple typologies and frameworks. The now dominant typology of varieties of capitalism classified both economies

as liberal market economies, characterized by relatively light regulation and a low degree of economic coordination (Hall and Soskice 2001). Esping-Andersen's seminal study of welfare states classified both welfare states as liberal welfare regimes, with welfare functioning only as a safety net for the neediest and a general reliance on the market; the United States, however, was a much neater example of this regime than the United Kingdom (Esping-Andersen 1990). In their work on changing employment systems in industrialized countries, Katz and Darbishire (2000) found that both the British and American economies have featured declining union representation, increased inequality, and similar variations in employment and human resources practices across industries.

In studying health care workplaces, it is essential to view the process of ongoing change in context—that is, as part of a series of relationships (or institutional interactions) stemming from and feeding back to these same institutions (Pierson 1994). In other words, the government and large employers—and indeed insurance companies—create policy using a variety of considerations from workplace consultation to electoral politics. A complex configuration of interests influences the direction of policy and its ultimate success.

The NHS is a huge single-payer, single-provider public health care system, covering the entire population of about 60 million people. In contrast, the US system is a primarily private system that features a predominantly employment-based insurance system and, until the implementation of the ACA, excluded about 50 million people from access to regular health care. The ownership, insurance, and payment structures in the two countries could not be more different. In the United States, health care is both the largest and the fastest growing industry and has more than 18 million employees in almost 1.4 million workplaces (US Bureau of Labor Statistics 2015)(Bureau of Labor Statistics 2008). In the United Kingdom, about 1.2 million people are directly employed by the NHS, with more providing outsourced support services and contracted core services (Workforce and Facilities Team 2015).

The UK health care system is highly centralized, with 90 percent of the entire health care sector owned and operated by the central government. In contrast, the US system is a tangled web of payers and providers. This includes private hospitals and insurance companies as well as some government-owned and -operated programs (in particular, the Veterans Administration

and the Indian Health Service) in addition to government-funded programs that are privately provided—most significantly Medicare and Medicaid. Ownership, payment, and access are the starkest differences between the US health care system and the British NHS.

In spite of major differences in the financing and ownership of these health care systems, there are important similarities. In both countries hospitals are the biggest organizations providing health care, and the government is the biggest purchaser of care. Inside the hospital workplaces in the two countries, the similarities become even more apparent. Entrenched professional roles, resistance to change, and shortages of skilled staff are key concerns in both countries.

Hospitals in both the United States and the United Kingdom face many of the same current pressures. These common pressures are elucidated in the cases in the chapters that follow. The push for increased accountability and monitoring, improved quality, centralized regulation and standardization, and the tug-of-war for and against privatization, competition, and neoliberalism are trends that can be seen across the Anglo-American systems. These forces cut across the operations of hospitals in both countries. They are the forces behind the changes that create the titular challenges of the cases described herein. These goals and objectives motivate the constant parade of changes in health care. These four categories represent the *what* of the changes, and the cases here describe the *how* of the changes—How do they start? How are they initiated and by whom? And when and why are they successful or unsuccessful?

Much of the research on health care institutions has placed health care within the broader institutions and relationships of the welfare state. Like other welfare institutions, such as education and pensions, health care straddles the public and private sectors. In the fields of political science and sociology there has been a vigorous debate among competing explanations for welfare state (including health care institutions) formation, expansion, and retrenchment. Most of these explanations focus on the entrenched interests of welfare beneficiaries rather than on providers. Many theories of the welfare state seek to explain the creation of the welfare state rather than changes in welfare state institutions (Immergut 1992; Mares 2000; Pizzorno 1978; Swenson 2002). The major theories focus on the policy aspects of the welfare state, specifically when and how major welfare legislation is created and passed (Giaimo and Manow 1999; Immergut 1992; Mares 2000; Pierson

1996; Pizzorno 1978; Swenson 2002). These scholars did not examine when, how, or whether this legislation, once passed, is implemented. Even Giaimo's examination of the implementation of health care reform analyzed only modes of health care financing, an aspect that does not explain the major changes in modes of service delivery in Britain. Her assertion that "employers and government policy makers, and their interest in cost containment have become the driving force behind welfare state reform" (2001, 334) may have been an accurate description of Britain in the Thatcher era, but it did not reflect the massive increase in health care spending in Britain or the United States in many (but not all) recent years.

The vertical-slice framework I use allows for the analysis of health care restructuring where the rubber meets the road, at the front line of health care provision. I track policy changes from the point of initiation, whether within the workplace or at the national level, to implementation at the front line of care delivery. Essential to my argument here is an understanding of policy feedback, as explicated by Paul Pierson (1994). As he argues, once welfare institutions and entitlements are entrenched in a society, the possibilities for change become constrained. He rightly shows that policies and welfare institutions create new and powerful interest groups that in turn shape future policy. This feedback effect, in its simplest form, is a demonstration of the way that past policy constrains future policy because of the role of entrenched interest groups. I contend that welfare state employees on the front line, in addition to recipients of welfare benefits on whom Pierson focuses, can shape the process and possibilities for welfare reform, particularly in the labor-intensive health care sector. The vertical slice, cutting across the whole system from the policy level to the workplace, allows us to see how policies and institutions create interest groups in the workplace, which in turn enable and constrain future policy and practice.

It is also worth noting that in the case of health care in Britain and the United States there is no retrenchment or decline. Instead, there has been a continual process of restructuring, coupled with an increase in employment and expenditure in both countries. Pierson's key examples of the process of policy feedback in the welfare state are of services and transfer payments under threat (such as housing and pension payments). In the case of health care restructuring, there is no direct organizing among service recipients. Rather, the service providers have much more to lose with the imposition of new ways of working and new governance structures in their workplaces.

Giaimo and Manow (1999) made a strong case for examining policy implementation as well as policy formation in the study of health care reform. In particular, they rebutted scholars who explained welfare policy reform by way of party politics: "We do not deny the importance of explanations focused on the political arena, but we find that they tell only part of the story of policy change. In particular, such explanations tend to focus on the legislative process and thus can only answer the question of whether a policy was enacted or not. They give only a partial explanation for why policy makers settled on the particular content of reforms and often fail to consider events within a given sector at the implementation stage" (969).

The framework I use affirms the assertion that policy implementation is crucial. Key workplace structures determine whether and how health care reform is implemented. Giaimo and Manow focus on the role of the health care payers in determining the possibilities for reform. This explanation seems somewhat apt for their US and German cases, but it cannot explain the British case in which private companies are eager to profit from health care and the key existing payer remains the state (Monbiot 2000). Payers may exert influence over the degree of marketization of health care provision, but employees can affect all forms of frontline service delivery with or without competition in both the public and private sectors.

The history of performance ratings in chapter 3 demonstrates the political effects of the policy changes envisioned by Pierson. It describes how the ratings regime brought out the interests of hospital managers, who in turn were able to eliminate the ratings policy. But while Pierson focuses on the interests of recipients of welfare benefits, I focus on the interests of welfare state employees and the workplace effects of policy changes.

Pierson has argued that interest groups create policy, and policies also create interest groups. His paradigmatic example is that of social security. According to Pierson, the US Social Security program created a group with common interests—the recipients—who then became an organized interest group—the American Association of Retired Persons (AARP). The AARP was a product of a particular policy, but it became a powerful interest group with the ability to influence future policy (Pierson 1994). In the case of health care, it is not only health care beneficiaries that have become an organized interest group but also health care providers. Although some scholars have shown the importance of physicians in the establishment of health care systems (Immergut 1992; Starr 1982), the creation of new inter-

est groups, with the exception of patient advocacy groups, and their ability to shape future policy has been largely ignored. This is particularly true of all nonphysician health care providers. The traditional professional status hierarchy is reinforced by scholars of health care change who, in many cases, foreground the role of physicians (and sometimes executives) while diminishing the essential roles of other staff groups.

There is a powerful feedback effect through which current health care institutions shape—or even create—interest groups, which in turn have a strong influence over the possibilities for future change and the production of future policy. It is not possible to understand this feedback effect by looking only at the policymaking level or only at the national level. Rather, much of the action that determines the future of both health care delivery and policy happens at the workplace, where managers and frontline staff are charged with implementing the barrage of new initiatives. The example of star ratings in the British NHS (set out in chapter 3) demonstrates how the distorted implementation of a policy at the workplace led to the abandonment of this policy.

Although change imposed from above can be problematic, there are exciting innovations trickling up from the front line. When they are present, unions are a key facilitator of feedback, although they are not the only outlet for frontline staff voice. The frontline professionals and staff who have the most direct and intimate knowledge of the challenges of their work frequently come up with initiatives that improve health care for everyone. At times, the initiatives can move from a single workplace to become the norm (whether through regulation or the dissemination of best practice). The use of checklists in surgery is one such initiative, albeit physician initiated rather than initiated by nurses or other health care staff (Berenholtz et al. 2004; Gawande 2009a; Pronovost et al. 2006), the mandatory use of safety needles to prevent needle-stick injuries (discussed in chapter 6) is another. These cases demonstrate the power of frontline workers' knowledge, which cannot be replicated by someone outside the organization. It is worth noting, however, that those programs created and promoted by physicians tend to achieve much quicker traction than those initiated by nurses, other health care professionals, or indeed lower status, lower paid staff in hospitals.

One of the primary tensions in hospitals is between managers and professionals. Professions have developed over centuries, with strong identities, professional autonomy, and respect for specific knowledge and skills (for

much more on the history of nursing and medicine, see Nelson 2001; Starr 1982). Traditionally, professionals have controlled entry to their own profession by controlling the licensure or credentialing process. In health care, nursing and medicine are the largest professions, but there are scores of other essential professionals such as pharmacists and social workers. Through the evolution of health care institutions in both countries, the role of nonprofessional managers has grown dramatically. Most hospitals now have a chief medical officer, a chief nursing officer, and a chief executive officer (although there is wide variation in actual job titles).

The chief executive is the final arbiter and theoretically sits above the top physician and nurse managers in the organizational hierarchy. In practice, however, it is almost impossible for a nonphysician to impose anything on the physicians against their will. Enter any hospital in the United Kingdom or the United States, and one encounters the constant complaints of doctors refusing to cooperate or follow orders, complaints emanating from management, nurses, and other staff. The professionals in turn assert that their professional authority trumps any suggestions or recommendation from nonprofessionals. This major tension exists in hospitals in both the United Kingdom and the United States and certainly transcends the structural and financial differences in the two health care systems. The relationship between management and professionals has the potential to strain implementation of any reform initiatives. For an initiative to succeed, all frontline staff generally have to agree on and support the process as well as the overarching objectives—lack of buy-in from professionals makes it impossible for management to make any changes.

## The Challenge to Change Now

The questions of the causes of and obstacles to successful changes to improve health care are more relevant now than ever. As health care workers face this flood of change initiatives, policymakers, health care researchers, administrators, and elite physicians are proposing one initiative after another to make health care safer, more rational, or more satisfying to patients. In the United States, the most sweeping health care legislation in decades promises to reshape access to and payment for health care without having much effect on

the health care workplace. The 2010 ACA mainly creates incremental change in the health insurance market, but policymakers and consultants, insurance companies and professionals are clamoring to take advantage of the opportunity to shape broader changes.

In the United Kingdom under Tony Blair's Labor government, the push was not to do more with less, but to do even more with more. Expenditure and employment increased, but so did the number of change initiatives. From performance monitoring to annual surveys of staff and patients, from the gradually increasing role of the private sector to the growth in use of nonprofessional staff (especially health care assistants), new initiatives and new pressures became the norm. The onslaught of change initiatives has continued, even as the coalition and then Conservative governments of David Cameron implemented austerity measures that choked off health service funding.

The British NHS is the most centralized and socialized health care system, while the United States system is the most fragmented and relies on private insurance and private provision of care. The differences in these systems are in access and payment, not in the delivery of care at the front line. In fact, hospitals in both countries bear striking similarities. As the following chapters elaborate, frontline workers in both countries face many of the same challenges, from interprofessional collaboration to infection control. While the British system is explicitly nationally regulated, the regulatory framework in the American system is less well known. Nevertheless, the scale of government-purchased health care and the scope of national regulation mean that hospitals in the United States are underpinned by a common set of rules of operation. Although payment systems in the United States are fragmented and access to health care is not universal, American hospitals are subject to uniform rules and pressures that have much in common with their counterparts in the United Kingdom.

Many in the United Kingdom see the US health care system as their worst nightmare: "Thank God for the NHS. Thank God the NHS didn't go the American way," said one general practitioner after seeing Michael Moore's film *Sicko* (Edemariam, Henley, and Khaleeli 2007). In the United States, the fear of socialized medicine was ever present in the 2009–10 health care reform debate, and ultimately the fear of stifling free markets led to the demise of a public health care option. In a laughable moment at the height

of the health care debate in the United States, former New York City mayor Rudolph Giuliani alleged, with blatant disregard for the facts, that if he had had prostate cancer in the United Kingdom rather than the United States, he would be dead. Yet as employees and patients of each system fear their idea of the other, the systems are moving gradually closer together, with an increase in government-purchased health care in the United States after the Medicaid expansion in the ACA, and a growing role for private providers contracted to the NHS in the United Kingdom.

While I focus of the difficulty of implementing change in both systems, my analysis secondarily sheds light on some of the essential similarities between hospitals in both countries. There is no better way to examine the dynamic between change at the micro and the macro levels than by looking at the two health care systems in the industrialized world that seem the most diametrically opposed: the United States and the United Kingdom. The primary research is contextualized with historical accounts of key moments of change in each system. The argument and the data presented in this book reveal that workers and managers in systems thought to be so dissimilar respond to change initiatives in similar ways. This insight helps us to understand the processes that influence system change and creates a much clearer picture of the importance of the front line in any potential systemic change. Exploring these similarities, I trace change initiatives imposed from above and those initiated at the workplace level. In the process, I demonstrate that many of the most significant and successful change initiatives in both countries have moved not from the macro level to the micro but from the micro to the macro.

My analysis of the two health care systems frames a key argument: not only do national institutions shape workplace relationships, but workplace relationships can also shape national institutions. Among the examples detailed in the chapters that follow are the workplace response to the Private Finance Initiative in the United Kingdom, which led to new regulations restricting the ability of private contractors to degrade the pay and conditions of privatized workers. Similarly, both the use of safety needles and the widespread adoption of checklists to eliminate errors and infections, practices that were initiated by frontline staff in US hospitals, have now become embedded in national regulations. In these cases of bottom-up change, we see that the configuration of national institutions does not determine the outcome in the workplace. Rather, the workplace relationships and the ability of employ-

ees to solve pressing problems by applying their own expertise and then propagating successful initiatives more broadly have reshaped national practice.

This argument stands in stark contrast to much of the established literature on employment relations. The received wisdom in political economy and industrial relations, as argued in numerous seminal books (including volumes by Hall and Soskice 2001; Katz and Darbishire 2000; Kochan, Katz, and McKersie 1986; Piore and Sabel 1984) is that national institutions shape workplace relationships. The influence of workplace relationships on national institutions, however, has been largely overlooked. Nevertheless, as I show in the chapters that follow, the experiences of workers on the front line can and do shape future policy.

Whether and how policy is both made and implemented is profoundly affected by what is happening in the workplace. Legislators and regulators cannot simply create change by writing it into the law. Rather, the messy reality of the workplace may distort, pervert, accelerate, or enhance the intended policy. Similarly, national change may begin in the workplace when frontline workers are most aware of the causes of problems and the likely areas for improvement. When local initiatives from frontline workers are successful, the policy diffuses and sometimes moves from a practice that is voluntary or covered in a collective bargaining agreement to a law covering all workplaces, regardless of employer or employee preferences or union coverage.

This book focuses directly on the relationship between national policy and workplace practice and the feedback dynamic that determines this relationship. National policy and institutions structure workplace relationships, which in turn have an impact on future policies and institutional changes. Too often one side of this two-way relationship has been overemphasized to the neglect of the other.

## Overview of the Chapters Ahead

To make a convincing case for a dynamic found across two countries and at the intersection of policy and practice, it is necessary to take a deep dive into each country's health care system before moving to the more contemporary cases. In chapters 1 and 2, I provide a history of each country's health care system with an introduction to the key stakeholders and an explanation of

how and why they came to hold their current positions. These are not comprehensive histories but rather long looks at the ongoing processes of change that have led to the current institutional configuration.

I contextualize the long history of change in health care in both countries and make detailed comparisons of the unending attempts at change in hospitals in both the United Kingdom and the United States. I introduce the key players in each system—the payers, providers, and patients—and explain how each system has evolved into its current form. In the case of the United Kingdom, the NHS hospitals were relatively constant from the service's founding in 1948 until the mid-1980s. Since the 1980s, change initiatives have proliferated, from the use of outsourcing to the emphasis on performance monitoring and restructured pay systems. NHS managers and staff alike are frustrated by the constant attempts at change imposed from above, often with little consultation of the frontline staff who will be responsible for implementation.

In the United States the fragmented health care system has seen nonstop changes for at least the last half century. With the introduction of Medicaid and Medicare requirements, hospitals reoriented their delivery systems; with the introduction and legislative encouragement of health maintenance organizations (HMOs), the systems were reoriented again. The role of the Joint Commission (formerly the Joint Commission on Accreditation of Healthcare Organizations, or JCAHO) is constantly evolving. The Joint Commission is the de facto national regulator of hospitals, so when the commission establishes a new requirement (as it does regularly), frontline staff are forced to respond to its directives. The initial chapters of this book illustrate that the current, sometimes fraught, relationship between national actors and frontline health care providers is determined by long-standing interests and is not a new phenomenon. They also show that both health care systems have experienced constant change, with very little time for a new equilibrium to ever take hold.

After the introduction of the two health care systems and the key stakeholders therein, I move in the subsequent chapters to crucial case studies. These cases trace the process of implementing change and look for the sources of success and failure in that process. Chapter 3 presents an in-depth case history that relates what is ultimately an episode of failed change from above. At the turn of the twenty-first century, the British government decided to impose a star rating system on British hospitals. This new system her-

alded a regime of reward and punishment that has been remarkably persistent, in spite of the fact that most frontline providers find it to be detrimental to the delivery of high-quality health care. An early example of the programs of accountability and performance measurement that have become central across the US and British health care systems, the star rating system was designed to reward good performance, punish poor performance, and enable easy comparisons. At the hospital level, however, the star rating system was manipulated, and managers had no confidence in the system. I present detailed evidence from my research in hospitals that received good ratings and those that received bad ratings that reveals that the system suffered from very low credibility and it never had the buy-in of the managers who were supposed to both implement and learn from the rating system. As a result, the managers, who resented the burden of data collection and did not feel motivated by the incentives that were supposedly inherent in the system, subverted the system. The ratings process was eventually abandoned (or at least adapted beyond recognition) in response to the deep subversion of the implementation process. The case of these performance ratings illustrates the power of frontline workers to embrace, reject, or indeed subvert national policy. The ultimate abandonment of this performance rating regime is a perfect example of the feedback effect, where the workplace relationships in turn affect national policy.

The example of change from above in the United States focuses on national regulation. The regulatory entity used in the United States is the Joint Commission (formerly known as JCAHO), which is officially voluntary but plays, as Chapter 4 details, the de facto role of a mandatory credentialing agency. Health insurance companies and government reimbursement programs have essentially ceded control of hospital accreditation to the Joint Commission, so the commission acts as a de facto national regulator, imposing uniform rules and standards on hospitals across the country. I analyze the central role of the Joint Commission in imposing new initiatives on US hospitals. Every time the Joint Commission introduces a new goal, hospital staff have little choice but to comply with it, almost regardless of any adverse effects. Chapter 4 analyzes the imposition and implementation of the Joint Commission requirements as a case of an ongoing attempt at change from above leading to intense frustration and change fatigue on the front line. Criticism of these requirements from frontline staff has ultimately led to a dismissive approach to the accreditation process, such that it is seen as

a wasteful bureaucratic exercise rather than an important check on patient care protocols. This is not so much a case of absolute failure but of major pushback at the point of implementation, after frontline workers have had a chance to wrestle with the impracticalities of the new rules and procedures.

In chapter 5 I show how the feedback loop works in practice. This case demonstrates pushback from the front line. Focusing on the United Kingdom, chapter 5 details the work of unions (especially UNISON) to build strong local organizations to fight the creeping privatization of the NHS. This chapter is based on research conducted jointly over several years with Stephen Bach, some of which has been published elsewhere (Bach and Givan 2010; Givan and Bach 2007). It was not a case of new policies initiated in the workplace but rather a case of feedback—workers and their unions were profoundly unhappy with the inequities that came with private sector involvement in the NHS, and they were ultimately able to force the government to protect the pay and conditions of their members. The union did fight the policy of privatization nationally (especially the Private Finance Initiative), but its most influential efforts took place in the workplace. Outsourced workers fought for better working conditions in their own hospitals while giving their national union the information and resources necessary ultimately to end the so-called two-tier workforce (the system in which workers doing the same job were paid differently depending on whether they had been employed by a public or private employer). In chapter 5 I show that change from above may beget change from below, and I demonstrate the feedback effect in action. The Private Finance Initiative created hospitals where staff worked under both public and private employers, with different terms, conditions, and benefits. The staff were able to organize themselves and respond with new initiatives, and ultimately they achieved a more equitable outcome.

In the next example of change initiated in the workplace I look at responses to the crisis in hospital safety for both patients and hospital staff. Although there have been problems with hospital safety for decades, a confluence of interests had made it difficult to legislate an improved safety culture in hospitals. In chapter 6, I provide an analysis of key safety initiatives, pushed by nurses and doctors, that have made hospitals safer places for all who set foot in them, employees or patients. I demonstrate how one nurse in one workplace took a stand that led to a national change. Lorraine Thiebaud was a nurse in San Francisco from the early days of the acquired immuno-

deficiency syndrome (AIDS) epidemic. After her coworker was infected with the human immunodeficiency virus (HIV) through a dangerous needle, Thiebaud took action. From the grievance procedure to a new collective bargaining agreement, and from a new state law to a new federal law, Thiebaud fought to mandate that employers purchase only safer (but more expensive) needles to protect the health and safety of their workers.

In my discussion I emphasize the importance of a multistakeholder perspective. Needle-stick injuries to staff may have only an indirect impact on patient care, but the sustainability of the workforce and the need to maintain adequate health and safety standards cannot be separated from high-quality patient care. A nurse working in an unsafe environment cannot provide the highest level of care to a patient. In this case, a nurse (and her union) recognized this and initiated a change that trickled up to the very highest level, federal legislation. I also discuss how surgical staff found a way to enforce hand-washing protocols and significantly reduce the incidence of potentially fatal central-line infections. The examples in chapter 6 demonstrate the process through which a nurse or doctor recognized a problem, developed a solution, and confronted the institutional barriers to implementing the solution. Through a gradual process, these frontline staff initiated policies that affect all US health care workers and patients.

In the conclusion, chapter 7, I draw findings from the in-depth case studies and reaffirm the feedback dynamic among legislation, regulation, and the workplace. My discussion moves from the workplace to the level of national institutions and national health care systems and revisits the relationship between workers on the front line and the implementation of national change. I show the ways in which health care providers are a critical interest group with the ability to veto, constrain, and undo attempts to change health care delivery. I elaborate on the relationship between the micro and macro levels and draw comparisons between the United Kingdom and the United States. This elucidates the claim that the US and UK health care systems are radically different in terms of payment and access but remarkably similar at the workplace level—for example, in their similar relationships between doctors and nurses. I emphasize the relationship between national health care institutions and the front line of health care delivery. As I return to the macro level, I make clear that it is not possible to understand the potential for systemic change in health care without understanding the dynamics of change at the site of most health care delivery, the hospital workplace.