

The Rise and Decline of Labor-Management Cooperation:

LESSONS FROM HEALTH CARE IN THE TWIN CITIES

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Labor-management cooperation has been viewed by many as the solution to firms' competitive woes. The popular press has lauded the joint efforts of companies and their unionized workforces to join forces to solve companies' competitive problems, save employees' jobs, and reinvigorate the American economy. Moreover, a considerable amount of academic research has been devoted to the study of these efforts, noting that through joint efforts, unions and firms can improve both organizational performance (quality and productivity) and employee outcomes (job security, wages, and job satisfaction).¹

Increasingly, however, it appears that cooperation may be but a short-lived phenomenon. Often after a period of initial success, cooperative efforts find themselves bogged down, no longer meeting one or more of the parties' needs, or held hostage to events taking place elsewhere in the parties' relationship. This waxing and waning of labor-management cooperation has been previously noted by scholars. However, the reasons for the rise and decline are not clear. For example, some have argued that cooperation arises during times in which management authority is challenged by labor. Thus, labor's cooperation is sought as a means to establish labor compliance, thus maintaining management's control over labor.² When labor's power diminishes, labor-management cooperation ends. Others, in contrast, have argued that management seeks labor's cooperation and involvement in workplace decision-making during times of competitive crisis.³ Management is willing to concede some degree of control to secure worker involvement in problem solving that will help improve the firm's competitive situation. Once the crisis is averted, then cooperation ends and management control is reasserted. In neither view are the mechanisms by which labor-management cooperation comes to an end specified.

The case presented in this article challenges both these views of the rise and decline of labor-management cooperation. Labor-management cooperation between more than a dozen hospitals in the Minneapolis/St. Paul, Minnesota, area and the Minnesota Nurses' Association (MNA) began in the mid-1980s when the parties came together to negotiate and manage the process of system integration, rationalization, and service delivery improvement. The rise of cooperation in the mid-1980s is predicted by both views of cooperation presented above. Not only did the hospitals face a severe financial crisis, but the MNA found itself with considerable power in the wake of a large, lengthy, and highly successful strike. Together these features prompted the creation of what grew to be a highly successful joint labor-management cooperative initiative. However, the next crisis to emerge—that of a nursing shortage that created huge financial difficulties for the hospitals and gave the MNA increased bargaining power and leverage vis-à-vis their employers (conditions similar to the mid-1980s period)—played a large part in the demise of the once-successful cooperative venture. By the late 1990s, labor-management cooperation no longer existed at the system level and only vestigial remains of cooperation were left in a few hospitals. Neither view presented above regarding the rise and decline of labor-management cooperation is consistent with this outcome.

Instead, there are challenges inherent to many labor-management cooperative initiatives that make them difficult to sustain. The Minnesota case sheds light on the reasons for the ultimate demise of labor-management cooperation, reasons that are generalizable to labor-management cooperative undertakings throughout the United States, especially those in less-troubled competitive circumstances than health care. Moreover, this case can shed light on the mechanisms by which labor-management cooperative efforts come to premature ends. Through a detailed understanding of this particular effort and the sources of its demise, union leaders and managers can learn from this case and increase the longevity of their own cooperative initiatives.

Labor-Management Cooperation in Different Industries

Since the early 1980s, labor-management cooperation has been adopted in a broad cross section of settings as firms and unions have sought to improve organizational and employee outcomes through joint initiatives in addressing competitive challenges. Empirically, labor-management cooperation has produced some notable successes. On the basis of a broad, national sample of large unionized firms, William Cooke finds that labor-management cooperation can improve productivity and product quality.⁴ Separately, an examination of the very intensive labor-management cooperation at Saturn finds that union involvement in decisions concerning product quality results in higher levels of first-time quality.⁵ In addition, several instances of labor-management cooperation including those at Xerox,⁶ Levi-Strauss,⁷ and in a group of luxury San Francisco hotels⁸ have been highlighted in the literature as playing a central role in improving both organizational performance and employee outcomes. The results

from both single cases and broad survey research seem to indicate a positive effect of labor-management cooperation.

Although this empirical evidence appears encouraging, many studies are based on a snapshot taken at one point in time. Despite the success of many labor-management cooperation programs, most programs—even successful ones—don't survive in the long term. There are those who blame labor-management cooperation's demise on the ending of management's need for labor compliance or on management no longer requiring labor's help because a period of economic crisis has passed. However, these commonly offered explanations are inadequate due to a variety of reasons.

The auto industry was one of the earliest adopters of union-management cooperation, beginning with Quality of Work Life Programs in the early 1970s. In their 1973 agreement, the automakers and the UAW included a letter of understanding promoting joint undertakings to improve the Quality of Work Life and ameliorate worker discontent for UAW members.⁹ After the competitive crisis that hit the North American auto industry in the late 1970s, the focus of these joint labor-management programs shifted from making workers happier to tapping workers' ideas for cutting production costs through more cooperative relations. Labor and management implemented employee involvement (EI) teams during the early 1980s, experimented with team forms of work organization, collapsed job categories, and began associating pay with skills, not with the job performed.

A number of plants experienced initial successes with the EI process—especially in terms of worker outcomes such as reduced absenteeism and fewer grievances.¹⁰ However, many such successes were short lived. Improved labor-management relations at one GM plant evaporated after a change in plant management and large-scale layoffs.¹¹ At Ford, a number of successful pilot projects were not enough to propel the process to broader adoption.¹² Unable to deal with new challenges or topics, once the easy projects were accomplished, the process withered and died. Concomitant with the ending of cooperation in many plants was also an easing of the financial crisis faced by management. Thus, the rise and decline of labor-management cooperation in many of these plants appears consistent with the argument that cooperation waxes and wanes in response to the financial crises faced by management.

Cooperative efforts also began in the early 1980s at Corning, Inc. Beginning with Total Quality Management as a means to recapture the company's competitiveness, the joint process between Corning management and leadership of the American Flint Glass Workers Union came to involve plant redesign along socio-technical system lines that eventually evolved into "Partnership."¹³ By the late 1980s and early 1990s, Partnership Steering Committees were established in all of Corning's AFGWU plants.

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The Partnership process was responsible for the dramatic 1992 turnaround at Corning's Erwin Ceramics plant. Under pressure for cost reductions from its customer, the plant underwent joint redesign.¹⁴ Management cited improvements of 18% in throughput time, a 44% reduction in defects, an 88% decline in errors, a 13% improvement in material utilization, and a 60% improvement in finishing throughput.¹⁵ Workers gained more pleasant working conditions, relief from supervisory monitoring, and wages grew from pay grade 6 to pay grade 16 under a new pay-for-skills program.¹⁶

However, another round of cost cutting in 1995 produced different results. Rather than deal jointly with the union, management decided to go "back to basics" and reassert control on the shop floor. While this initiative led to significant improvements in performance, for workers the turnaround was traumatic. The union was unable to affect the direction of "joint" undertakings or even significantly curtail company downsizing, including the loss of more than 500 jobs between 1997 and 1999. As a result, "Partnership" at Corning is effectively dead. In this case, despite a continuing financial crisis, management ended cooperation by reasserting its control on the shop floor. Thus, the rise and decline of labor-management cooperation at Corning appears consistent with the argument that labor-management cooperation waxes and wanes in response to management's need to control the power of labor. Finding an alternative mechanism (the "back to basics" movement), management effectively ended joint activities.

A slightly different story emerges from the steel industry. In the late 1980s, Inland Steel and United Steelworker Local 1010 faced severe competition from mini-mills and imported steel in the bar market. To survive, Inland needed to reduce costs by \$40 per ton. Through a cooperative process that included joint committees at the plant, department, and shop floor levels, labor and management jointly redesigned jobs to accomplish the cost-cutting objective.¹⁷ The results were impressive: management reduced costs by \$40 per ton, increased market share from 7% to 10%, and improved quality; workers earned on average \$.25 more per hour (with some increases up to \$2 per hour), their skills increased through cross training and the addition of minor maintenance skills, and they worked with greater autonomy as supervision was greatly reduced.¹⁸

The process the parties used became institutionalized within the plant and guided considerable amounts of subsequent restructuring. It was formally enshrined in the 1993 Partnership Agreement. In addition to access to workplace decision making, the union also gained a representative on the company's board of directors and extracted from Inland Steel a neutrality pledge with respect to new organizing. The latter pledge, however, was to prove the undoing of labor-management cooperation. By the late 1990s, Local 1010 grew so frustrated with what it perceived to be management's lack of neutrality that the local union withdrew from all aspects of joint activities, ending the Partnership. Although a competitive crisis prompted management to engage labor in a cooperative undertaking to improve outcomes on the shop floor, cooperation eventually ended with withdrawal by a strong union. Cooperation's demise in this case

is not consistent with either explanation offered earlier—either the end of a financial crisis or the elimination of the need to control the power of labor.

These cases all illustrate the demise of high-profile instances of labor-management cooperation, all of which at one time or another were considered successful and delivered significant benefits to the parties involved. All, however, eventually dissolved and for a varied set of reasons. No clear pattern consistent with either of the two explanations offered earlier emerges. The Minnesota health care case contains many of these same elements and also ends with the dissolution of labor-management cooperation.

Labor-Management Cooperation in the Twin Cities: The Context

The case material presented here was gathered in extensive fieldwork conducted during 1995 and 1996. In 1994, leaders among hospital management and involved unions invited the first author to conduct research examining two questions of central interest. First, what were the effects of labor-management cooperation on hospital capacity to respond to shifts in patient populations and changing competitive demands?¹⁹ Second, what were the effects of alternative work practices on the quality of patient care?²⁰ The project entailed dozens of interviews with representatives of hospital management and the Minnesota Nurses Association. In addition, a survey of over 1,600 nurses at 15 hospitals in Minneapolis/St. Paul conducted in 1995 provided insight into employees' perspectives on cooperation at that time.²¹ Additional material for this article was gathered in recent follow up interviews by both authors.

For the past twenty years, the health care industry has been undergoing broad-scale restructuring. Initiatives by private employers to control the spiraling costs of health care, combined with pressure by the federal and state governments to control Medicare and Medicaid costs, have put increased pressure on health care providers to control costs and have led to broad changes in the organization and provision of health care. The result has been a dramatic shift away from fee-for-service and towards managed care providers, with important impacts on the competitive environment of hospitals.

The Minneapolis/St. Paul health care market was an early adopter of managed care and was a pioneer in the development of an integrated delivery system. The first HMO in the Twin Cities, Group Health, Inc., was formed in 1957 as a consumer cooperative. Group Health employed salaried physicians and contracted with local hospitals for services. While Group Health, and managed care generally, was initially considered inferior to traditional care delivery models, the local perception of HMOs changed in 1972 when a leading, multi-specialty physician group practice created an HMO in response to local employer interest. This shift in perception and demand began a period of growth in HMO membership in the Twin Cities. Between 1971 and 1978, HMO membership grew at a 27 percent annual rate with 12.4 percent of the Twin Cities' population enrolled in one of seven available HMOs by 1978. During the 1980s, HMO growth was further promoted by a revision in Minnesota state policy encourag-

FIGURE 1. The Formation of Hospital Systems in the Twin Cities

Year	Hospital Merger
1982	LifeSpan is created with the merger of one large urban hospital with two smaller rural hospitals
1986	HealthEast is formed with the merger of five hospitals in St. Paul
1987	Fairview Health Services expands with the addition of one hospital (St. Mary's Hospital)
1987	HealthOne Corporation is formed by the merger of two existing multi-hospital systems (Health One and HealthCentral)
1993	HealthSpan Health Systems Corporation is created by the merger of HealthOne Corporation and LifeSpan
1993	Allina is formed by the merger of HealthSpan Health Systems with Medica (an HMO)
1997	Fairview-University Medical Center is formed by the merger of University of Minnesota Hospital and Fairview Health Services
1998	Fairview-University Medical Center and Allina control 50 percent of the market
1998	Fairview-University, Allina, and HealthEast control 64.5 percent of the market

ing the use of HMOs by state employees. Moreover, employers began demanding increasing cost control in the provision of health care to employees and thus were more favorably disposed towards HMOs. By 1992, 44 percent of the population in the Twin Cities was enrolled in an HMO, one of the highest levels of HMO penetration in the country.

The result of this high level of HMO penetration was a shift in the competitive dynamics of the Twin Cities' health care market. HMO success is driven by the reduction of health care delivery costs. As hospitals are high-cost sites of health care delivery, HMOs seek to limit physicians' use of hospital services; and by the 1980s, HMOs began to significantly decrease hospital admissions and the average length of stay. Moreover, HMOs used hospital charges as a means of selecting "preferred" hospitals for physician referrals. The result was growing pressure on hospitals to alter patient care delivery and overall cost structures as many of them suffered financial losses throughout the 1980s.

In response, six of thirty-five hospitals in the Twin Cities closed between 1971 and 1990 and the number of hospital beds per 1,000 people fell from 5.1 to 3.0,²² primarily as a result of these closures. In addition, the occupancy rates in the remaining hospitals also fell: from 84 percent in 1986 to 59 percent in 1994. The 1980s also witnessed the beginning of the movement towards merged hospital systems. Figure 1 shows a timeline of merger activity. By 1987, four hospital systems had emerged to dominate the Twin Cities market with over 50 percent of all admissions. By 1998, further mergers and continued consolidation left three hospital systems accounting for 64.5 percent of all inpatient days.²³

These mergers served multiple functions including increasing hospital market power in negotiations with HMOs, reducing administrative costs through common overhead, and improving access to capital markets.²⁴ These changes in the industrial structure led to clear improvements in financial performance. As well, the creation of larger hospital systems increased the potential for employee

transfers in the wake of hospital closures and downsizing. During this restructuring, hospital labor-management relations played a central role both in shaping the process of change as well as the eventual practices observed within hospitals.

Labor-Management Cooperation in the Twin Cities: Evolution

In contrast to other regions in the country, union density in the health care sector has historically been very high in the Twin Cities. In 1989, the Minnesota Nurses Association represented 91 percent of all registered nurses (RNs) in the Twin Cities. Other unions, including the Service Employees International Union (SEIU), the International Union of Operating Engineers (IUOE), the Minnesota Licensed Practical Nurses Association (MLPNA), the Association of Diagnostic and Imaging Technologists (ADIT), and the American Federation of State, County, and Municipal Employees (AFSCME), represented nearly 50 percent of non-RN health care workers in 1989.²⁵

This unusually high unionization rate of hospital employees greatly affected the character of labor-management relations in the Twin Cities. Beginning in the mid-1950s, the hospitals and unions began negotiating area-wide contracts to standardize employment costs. These multi-employer negotiations typically included all local unionized hospitals. The few non-union hospitals matched negotiated wages and benefits to prevent unionization.

Contract negotiations in 1984 proved to be a turning point in the decades-long tradition of relatively amicable rounds of negotiation between the hospitals and the MNA. In 1984, the hospitals and the MNA sat down to bargain a new contract in the context of the dramatic external changes then taking place. The recent growth of HMOs and the shift in Medicare reimbursement from cost-plus to a prospective payment system based on patient diagnoses and acuity signaled a new health care environment. Hospitals were already closing beds and reducing the number of nurses on staff. In addition, tensions were heightened between some hospitals and the MNA with the decision by some hospitals to lay off some of their most senior and highest paid nurses. While hospitals sought to increase staffing flexibility, RNs wished to ensure some control over the process and increase job security through the use of seniority as the basis for determining layoffs. Going into the 1984 negotiations, it seemed that a strike was inevitable. The acrimonious negotiations that followed ended in the largest nursing strike in U.S. history with 6,300 nurses striking 16 hospitals for 39 days. In the end, the nurses won as the hospitals agreed to adopt seniority as the basis for future layoffs.

Prior to impasse however, two hospitals had removed themselves from the multi-employer bargaining table in an effort to avoid the growing tension within the local health care community. Although they ended up paying higher wages, they successfully avoided a strike and the animosity associated with it. Enjoying relatively amicable labor-management relations with the MNA, these two hospitals were the only unionized facilities to be open during the citywide strike. Knowing that future challenges lay ahead due to the drastic changes in

their environment, labor and management at these two hospitals decided to build on their history of open relations and to experiment with formal labor-management cooperation as a means of addressing future challenges.

Initiation

The two hospitals, along with the MNA, engaged the local Federal Mediation and Conciliation Service (FMCS) and the State Bureau of Mediation Services with the objective of building a closer working relationship and improving communication between the union and the hospitals. An 18-month FMCS grant received by the parties paid for a facilitator to work internally at both hospital sites and help the parties establish a labor-management committee at each hospital composed of top hospital and MNA leadership. Together, the parties decided on some key topics to work on jointly: absenteeism, a vacation scheduling system, ways to improve communication, and a way to ease access to educational programs for RNs. When the grant term ended, the union and the hospitals opted to continue their joint processes, formalized the joint labor-management committees, and hired the facilitator as an internal consultant.

Diffusion

Between 1984 and 1989, labor-management cooperation diffused very slowly. In 1987, two hospital systems merged. The vice presidents of human resources at two of the hospitals were key actors in driving the labor-management cooperation process throughout the new corporate entity. As a result, cooperation that was slowly developing in two hospitals began to spread to other hospitals in the now merged system. Even though there was increasing pressure on hospitals to restructure and cut costs, by 1989 only 4 hospitals had formal labor-management committees. Despite the slowness of formal diffusion however, support was building for labor-management cooperation among hospitals and unions in the Twin Cities.

In 1989, corporate human resource managers from several hospitals and union leaders that were jointly engaged in labor-management cooperation came together to form the Metropolitan Hospitals' Labor-Management Council (MHLMC) to promote the expansion of labor-management cooperation in the Twin Cities. The purpose of the council was to share experiences and learning across hospitals as they figured out how to manage labor-management cooperation. The group shared topics individual committees were working on, programs they were developing, and reported on outcomes. The creation of the Metropolitan Hospital's Labor-Management Council became a tool both to extend cooperation within those hospitals where it already existed and, perhaps more importantly, to spread cooperation to hospitals where there was only moderate support for it. As a Vice President of Human Resources at one hospital suggested, the MHLMC provided cover within the hospital for adopting a strategic direction towards cooperation that helped reduce personal risk for human resource managers.

The potential of labor-management cooperation was highlighted soon after the formation of the MHLMC. In 1991, a large Twin Cities hospital closed. With close collaboration amongst hospitals and unions, nearly 90 percent of the 1,475 employees were placed in new jobs. This outcome highlighted the potential of cooperation in an era of on-going restructuring and the value to all parties of working together to address problems.

With the help of such positive examples of cooperation as the relocation of hundreds of displaced hospital employees, cooperation diffused rapidly during the early 1990s and membership in the MHLMC expanded. Within hospitals, the typical labor-management committee (LMC) met monthly. It would be composed of the most senior human resource manager on site, the chair of the bargaining unit, the chief nursing executive, an MNA staff representative, and a representative from the director level on the nursing side. This relatively small committee would also designate subordinate committees as needed to work on particular projects. Issues to work on would be solicited from both employees and managers in monthly staff meetings. Overall, the intention of the LMC was to improve interaction between the union and hospital management in all aspects of their relationship.

The increase in the diffusion of labor-management cooperation prompted a concomitant movement in the multi-employer bargaining process. For some time, traditional bargaining tactics and strategies had sat uncomfortably with the parties' more open relationship during the life of the contract. For several months prior to negotiations, cooperative relations would slowly be replaced by more traditional relations with less information sharing. Moreover, the trust broken during adversarial negotiations would always need repair following the conclusion of bargaining. In response, both union leaders and hospital administrators felt negotiations should adopt the characteristics of the more open discussions seen in the rest of the relationship. The result was a shift to interest-based bargaining for the 1995 round of contract negotiations.²⁶ According to participants, the shift in bargaining strategy served to reinforce and strengthen cooperation within the hospitals.

An important outcome of the 1995 negotiations was the decision of the parties to enshrine in that year's collective agreement the requirement to set up LMCs at each signatory site. Thus, by 1996, every hospital with unionized nurses had at least one LMC. Significant differences, however, existed among the hospitals. Some hospitals had engaged in cooperation for a decade by this point, while others were just taking the first steps to improving communication. Thus, how LMCs were actually implemented and the role they played varied considerably across hospitals. This variation would later create tensions amongst Twin City hospitals as well as within the MNA.

Tensions

Continued cost pressures and the varied competitive situations in which hospitals found themselves placed increasing tension on the multi-employer format of labor-management cooperation in the Twin Cities. In particular, ten-

sions were building within the MHLMC. From the beginning, the MHLMC needed to balance cooperation and competition between member hospitals. While initially the hospitals only competed with hospitals in their immediate area, following consolidation in the industry, hospital systems spread throughout the region competed with one another extensively for patients, physicians, and health insurance contracts. As always, hospitals—and, then later, systems—also competed for employees. Endeavors that hospitals were undertaking jointly with the MNA to make their workplace a more attractive place of employment were not always freely shared for fear of copying and employee poaching. This ongoing tension became exacerbated over time. As well, the MHLMC came to have fewer high-value activities on its agenda as the initial projects (such as easing downsizing, coping with hospital closures, and improving overall relations) were successfully accomplished. Originally scheduled to meet monthly, the council eventually came to meet only quarterly.

Hospitals also differed in the degree to which they wanted to pursue cooperative relations with their unions. Some clearly believed that their cooperative activities provided a key source of competitive advantage and wished to continue and deepen their cooperative undertakings. Other hospitals preferred a more traditional, arm's-length approach to labor relations. They did not want to invest the resources required to develop such deep levels of involvement and preferred to seek competitive advantage from other sources. These two strategic choices clashed in the context of multi-employer negotiations and within the MHLMC.

More generally, hospital administrators also wanted the flexibility to negotiate contracts that reflected *their* competitive needs. Different hospitals and hospital systems were seeking to adopt contracts that supported their specific patient care and market strategies. As a result, many hospital administrators felt that they spent more time negotiating with each other than with the MNA. For example, several hospitals wanted to raise LPN wages to increase the available supply. In contrast, other hospitals feared such an increase would force them to also increase nursing assistant wages, negatively affecting their bottom line. Even within the 1995 round of bargaining between the MNA and the hospitals, one hospital chose to negotiate separately with the union. While the parties did not expect to develop a dramatically different contract, they wanted to focus the discussion and process on issues specific to that hospital. Moreover, the intention was to initiate a process that over a decade would enable the adoption of a labor-management contract that more closely fit the issues and strategy of that hospital.

Employee reactions to cooperation also began to sour over time. Initially, employees saw labor-management cooperation as the panacea that would cure their workplace woes. When those problems did not disappear, cooperation was blamed. Although employee expectations may have been unrealistically high, any mistake made by the cooperative process or any undertaking that employees didn't like began to be attributed to labor-management cooperation. After sev-

eral years, members came to desire particular outcomes and if frustrated in achieving them, simply blamed cooperation for that fact.

Breakdown

The tensions observed within the 1995 negotiations between the MNA and the hospitals eventually led to the collapse of the MHLMC. While the 1995 contract for the first time mandated the adoption of a formal labor-management committee at each hospital, it was at this point that hospitals were beginning to express a greater desire to move in distinct strategic directions. As hospitals diverged in their strategic approaches to labor-management relations, pressure increased within the MHLMC. Hospitals wishing to maintain arm's-length relations with their unions did not want hospitals with extensive labor-management cooperation to limit their actions. Conversely, one hospital system, which had extensive cooperation and union involvement in decision making at all levels of the organization, did not want its cooperative relations damaged in any way through spillover effects. This growing differentiation among hospitals was placing strain on individual cooperative efforts as well as on the MHLMC.

The final straw came with the privatization of the University of Minnesota Hospital and its sale to another system in 1997. Two AFSCME units at the university hospital did not have analogous units within the acquiring system. The new owner refused to recognize the units automatically and forced AFSCME to go through an election process to regain representation rights for these employees. As part of the election process, the new owner engaged the services of a labor relations firm perceived by the MNA to be a union-busting operation brought in to prevent an AFSCME win. Unable to countenance this employer behavior within the MHLMC, the MNA asked the other employers to put pressure on the new owner to stop using the services of this consulting firm. While the hospitals felt that this request of them went beyond legitimate expectations, the MNA felt it was a clear test of the value placed on citywide cooperation. After several months, the MNA withdrew from the MHLMC in protest, leading to the break up of the MHLMC. Neither the MNA, a prime supporter of cooperation, nor the individual hospital systems, which had now adopted distinct strategic approaches to cooperation, felt the need to continue community-wide cooperation.

In 1998, bargaining tensions mounted as negotiations approached. Moreover, with the adoption of distinct strategic directions by each hospital system, the parties did not engage in multi-employer bargaining for the first time in many years, but rather bargained in a coordinated fashion, each hospital on its own with its union representatives. To maintain coordination across hospitals, the Labor Relations Committee, an arm of the employer association Metropolitan Hospital and Healthcare Partnership (MHHP), worked with the hospitals. While bargaining concluded satisfactorily, both the parties experienced a tension-filled process. Each side required considerable amounts of internal negotiation to maintain coordination. In the case of the MNA, leaders worked very hard to keep conflicts within the union from flaring up. The process was becoming

increasingly strained. By the next round of bargaining in 2001, though the MHHP continued to work with the hospitals and coordinate the bargaining of common issues such as the citywide pension plan, the tensions resulting from increasing differences in nursing practices and strategic directions led to the elimination of coordinated bargaining in the Twin Cities. The 2001 negotiations would occur independently for each hospital and would reflect the labor-management relations and competitive issues facing each hospital.

As the 2001 negotiations approached, wide differences existed between the stated demands of the two parties. By this point, hospitals nationally were in the midst of a significant and growing nursing shortage. Moreover, with an inability to hire sufficient nurses, many hospitals not only increased the use of contract or temporary nurses but also required mandatory overtime for many of their employees. In response, union leaders suggested wage increases of 60-100% over three years as a way to increase retention of nurses and expand the future labor pool of nurses. In contrast, hospital management suggested increases of approximately 10% over the same time frame. In addition, each side had very different approaches to addressing the nursing shortage in the Twin Cities as well as the issue of nurse staffing levels. It soon became clear that a nursing strike was highly possible. Several hospitals went as far as contracting with temporary nursing agencies to staff their hospitals, at great expense, in case of a strike. By the end of negotiations, nurses at two hospitals struck for 23 days, with a number of other last-minute agreements being signed that narrowly averted several other strikes. Moreover, even at those hospitals that achieved an eleventh-hour agreement, the nurses were clearly split in their support for the contract with nearly 50 percent in favor and 50 percent opposed.

Overall, contracts at different hospitals and systems began to diverge more clearly in two important areas. First, wage settlements varied across the hospitals. Second, methods to address staffing levels and patient workloads varied as some hospitals set up joint committees to consider ways to address staffing concerns while others adopted specific mechanisms whereby nurses on the unit would be directly involved in setting staffing levels. In these latter hospitals, the new contracts gave the charge nurse, a union member, more authority to restrict the number of patients admitted to the unit. Ironically, with the end of the 2001 negotiations, the parties found themselves living with the heightened tensions and anger in the aftermath of the strained negotiations while at the same time continuing to rely on labor-management cooperation to address difficult issues such as staffing intensity.

Lessons From Experience of Labor-Management Cooperation in Twin Cities Health Care

It is becoming increasingly clear after nearly two decades of experimentation with labor-management cooperation that cooperation is at best extremely fragile and, perhaps more realistically, is a relatively short-lived phenomenon.

Based on the Twin Cities case, the following are the challenges inherent in many cooperative initiatives that all too often lead to their demise.

Multi-employer bargaining and community-wide cooperation proved overly constraining.

Multi-employer bargaining and the MHLMC served as critical institutions for the diffusion of labor-management cooperation in the Twin Cities. The 1995 collective agreement mandating LMCs at all signatory hospitals, however, also proved to come at the heyday of multi-employer bargaining and labor-management cooperation. By the time formal labor management committees were enshrined in the MNA collective agreement, differences across hospitals had grown, reducing the benefits of multi-employer bargaining and community-wide cooperation. In the end, multi-employer bargaining and the MHLMC proved too constraining for hospital-specific labor-management cooperation to play out in ways that met the parties' workplace-specific interests.

By the mid-1990s, the MHLMC and multi-employer bargaining posed significant constraints for hospitals' different approaches to labor-management cooperation. While some hospitals sought to adopt strategic cooperation, others only grudgingly adopted formal committees and tried to minimize their role in the hospital. With the presence of multi-employer bargaining and the MHLMC, the decisions made by one labor-management committee could often have implications for other hospitals. The example mentioned earlier of hospital leaders disagreeing over desired wage rates for different employee groups is illustrative of the cross-hospital constraints that emerged. Where hospital leaders at one facility wanted to increase wages for LPNs, others who did not use this occupational group within their care model were more concerned about the implications for nursing assistant and registered nurse wages. Solving a particular problem at one hospital frequently had negative ramifications at others resulting in an inability of the one hospital to act in its own best interest.

Moreover, the benefits of community-wide cooperation either through multi-employer bargaining or through the MHLMC were eventually swamped by the costs associated with intra-party negotiations. Some hospital leaders suggested that the negotiations among hospitals were more difficult than the negotiations with the MNA during the 1995 contract bargaining. Similarly, tensions within the MNA were also mounting due to differences in employer strategies and the implications for MNA member wages and working conditions at different hospitals. As such differences emerged, they created greater disparity in employee expectations regarding the outcomes of future negotiations. As a result, intra-union negotiations became of critical importance and increasingly time consuming.

Over time, these tensions between the hospitals over the nature of labor-management cooperation—as well as the expectation by the union that the hospitals were jointly responsible for maintaining cooperation and cooperative relations—led to the demise of the Metropolitan Hospitals Labor-Management Council. As mentioned earlier, the MHLMC finally disbanded when the MNA

wanted participating hospitals to publicly support the MNA's position against a member hospital during an organizing campaign. In contrast, the hospital leaders felt that each hospital should be able to determine its own strategic direction.

This account is consistent with findings from research conducted by Harry Katz to understand the decentralization of collective bargaining across six countries.²⁷ The reasons that multi-employer bargaining began to break down appear very similar to the strains on multi-employer initiatives into labor-management cooperation. For example, Katz found significant pressures for decentralization in bargaining coming from employers' unique needs to restructure on the shop floor. Local actors need to be involved in redesigning work systems and negotiating changes that fit their individual and often idiosyncratic needs. As well, Katz found pressures for decentralization coming from increasing levels of corporate diversification. In response to growing economic pressure and volatility in markets, companies begin to diversify and to pursue different markets and customers from one another. Thus, a common approach to workplace regulation no longer worked equally well for all. The result was increasing pressure for decentralization.

To overcome these constraint-related problems, union leaders and managers must be aware of two critical variables: the context in which cooperation is taking place and the needs of the parties involved. By being able to reassess the environment and their changing needs in it, the parties in the Twin Cities' case might have seen that the MHLMC's role needed to change after 1995. The initial purpose of the MHLMC was to help in the diffusion of labor-management cooperation throughout the Twin Cities' hospital sector. Once the collective agreement had successfully achieved that objective by mandating the presence of LMCs within each signatory hospital, the MHLMC's role needed to be re-evaluated. Most likely it could have served a valuable role in acting as an information clearing house (one of its initial roles) and as a source of training for LMC members within the hospitals. Most critically, the MHLMC had to distance itself from hospital-level negotiations and involvement. Potentially, it might have acted as a coordinating institution for common issues such as the pension plan (as the MHHP later did). Such a transition, however, would have required the parties on the MHLMC to reassess members' needs as the context changed and to re-evaluate and change the institution's role if needed.

Structures did not adapt to new issues over time.

Hospital LMCs were created with a particular mission and were institutionalized as operating with a given set of individuals. For most of the topics that the committees addressed in the peak years of LMC use (the early to mid-1990s), interaction at the hospital level was appropriate as the parties negotiated over downsizing, the merger of hospitals, and the adoption of alternative models of patient care delivery.

As problems common across hospitals got dealt with in the early years of labor-management cooperation, hospitals then turned to deal with issues specific to their patient mix, case specialty, and workforce. These issues were all intra-

hospital in nature. The more macro-level LMC established at the hospital was inadequate for addressing unit-level issues and was unable to involve nurses and managers at the floor level in a meaningful way. The LMC structures were never taken over and used by the people doing the work inside the hospital. More precisely, nurses working in the hospitals had little or no direct access to the LMC and therefore no way to actively participate in solving problems of most relevance to them. This is borne out by survey evidence from 1995 in which nurses at 15 hospitals with LMCs were asked about their direct involvement in making unit-level decisions. Overall there was little difference in the levels of direct participation by nurses in hospitals with long-running LMCs compared to nurses in hospitals with relatively new committees.

This dynamic can be observed in the hospital and union response to the most important issue facing RNs nationally in the late 1990s and early 2000s, namely, nursing workload and the determination of adequate levels of staffing on nursing units. While staffing levels were designed for average patient occupancy rates, it became increasingly frequent that occupancy rates rose above these levels. Nurses then became swamped with high numbers of patients to care for and were often required to stay overtime to ensure minimum-safe staffing levels. Much of the unrest surrounding the negotiation of the 2001 contract concerned this issue and it was this that led nurses at two Twin Cities' hospitals to strike. While the existing labor-management committees had representation from senior hospital and union leadership, the workload issue required the ongoing involvement of floor nursing staff and first-line managers. This level of involvement was not incorporated into existing structures.

The same phenomenon could be seen at Corning, Inc. in the late 1990s. After several years of highly successful labor-management cooperation around joint plant redesign, cooperation came to a virtual end after management asserted control on the shop floor as part of its "back to basics" program. For several years, going back to the late 1980s, top-level union officials from the national union toured with management to jointly evaluate and then negotiate the redesign of work systems at several Corning manufacturing facilities. The process was generally perceived by both those within the company as well as outside observers to be highly effective.

However, as restructuring moved to a more micro level, to on-going reorganization of work and serial investments in new technology simultaneously across many plants, cooperation faltered. Union representation in individual plants was sparse (due to the union's amalgamated local structure in which one local covers as many as ten individual plants) and the in-plant union representatives did not have the necessary training, skills, or union support to engage successfully with management in the cooperative process. Ultimately, management made the changes unilaterally with little participation or counter-argument from the union. The union did not have the structures in place nor the internal capacities needed to undertake labor-management involvement at this more micro level where it came to be needed.

For whatever reason, structures initially put into place tend to remain fixed and unchanging over time. Practitioners working in cooperative undertakings ought to be aware of the need for change and evolution in the cooperative undertaking's infrastructure as the problems in their environment change—for example, the need to deal with nursing workload as opposed to transferring nurses from a closing hospital into one that remained open. New institutions may need to be constructed, different people may need to become involved, and new resources may have to be brought to bear. Building the ability to reassess the parties' needs and the ability to evolve the cooperative structures will likely prolong the life of a labor-management cooperative undertaking.

Cooperation came to be blamed for many of employees' woes.

In response to the growing financial pressures facing hospitals, increases in both labor-management cooperation as well as extensive restructuring, re-engineering, and work reorganization occurred in the Twin Cities' health care sector. While cooperation enabled and improved the outcomes of many restructuring initiatives, the often-significant changes may also have led to the eventual demise of cooperation.

In efforts to reduce costs while maintaining levels of care, hospitals experimented extensively with the patient care delivery model. One notable strategy many hospitals sought to adopt was patient-focused care. Hospitals adopting this model often undertook significant physical changes in infrastructure as well as transformations in the role of the registered nurse versus assistive personnel (including licensed practical nurses and nursing assistants). As part of these changes, services within the hospital (e.g., lab, pharmacy, radiology) were relocated to bring them physically closer to the patient. In addition, the distribution of work across employee groups was reorganized. In many cases, the parties worked very closely to redesign roles, reorganize work structures, and redesign hospital infrastructure. Even where such negotiations were judged to have been successful and a thoroughly acceptable model of patient care had been designed, nurses often came to blame their union and cooperation for the pain the change process inevitably produced. Many nurses felt that their way of working was disrupted by the new model. They often faced considerable personal disruption as they were asked to carry out their duties in new ways, or were asked to work in different areas due to seniority-based bumping within hospitals.

Throughout all of these changes—hospital downsizing, employee transfers, and the implementation of new patient care models—labor-management committees played an important role in representing employees' interests. It was rare, however, that cooperation actually improved pre-existing conditions. While these instances did occur, they affected relatively few employees. At the same time, the one issue that could have delivered substantial and real benefits to nurses—that of dealing with the problems of excess overtime and inadequate staffing levels brought about by the nursing shortage of the late 1990s—was not initially taken up by the parties in a cooperative venture. Instead, from an employee perspective, the so-called benefits from labor-management coopera-

tion were nothing more than an amelioration of a worsened situation. In other words, much of what labor-management cooperation achieved was to reduce the pain from the losses employees were experiencing during restructuring. As a result, nurses began to place the blame for these disruptions on their union representatives who had negotiated such changes on their behalf in the forum of labor-management cooperation.

The souring of employee views of cooperation over time is noted in the 1995 employee survey in which employees in hospitals with the longest-running labor-management committees reported feeling that union-management relations were good in their hospital, but that union leadership was too friendly with the hospital administration. Moreover, employees in hospitals with longer-running committees expressed weaker support for labor-management cooperation than employees in hospitals with newer committees.

Similar experiences of backlash have occurred in manufacturing settings as well. Although the Saturn corporation was founded on the principal and guiding philosophy of cooperation (or "jointness" as it is known there), Saturn has also had to deal with some of the fallout from UAW Local 1853 members' perceptions of what cooperation has meant for them. In April 1999, the long-standing union administration was voted out after 12 years in office. Replaced by a slate running on a platform of reform, the new union leaders wished to take back increased control over their work lives. Although not rejecting "jointness" out of hand, the new leadership certainly wished to curtail what it perceived to be some of the excesses of labor-management cooperation. Members were frustrated by what they perceived to be the politics of the selection process in which full-time union representatives were chosen jointly by the union and management.²⁸ The new administration is working toward having representatives elected solely by union members.

Union representatives and managers need to be aware of the potential for cooperation to be inevitably blamed for employee woes. In particular, this scenario highlights the need for on-going dialogue between union leaders and their members. The greater the level of union democracy, the more likely it is that union leaders are aware of and can communicate to management the central needs and concerns of the membership. At the same time, the more robust the level of union democracy, the more likely it is that union leaders are able to communicate effectively to their members what management is and is not able to do.

Although worker input to workplace decision making is often seen as an increase in workplace democracy, it is not necessarily an increase in union democracy. Labor-management cooperation often focuses attention on the needs of the business and issues of competitiveness to the detriment of interests of particular concern to workers themselves and of the working class more generally.²⁹ If managers and union leaders seek to develop cooperation as a long-term approach to working together, they must also use cooperation as a path to addressing factors that employees see as critical to improving their working conditions. Topics for discussion cannot be limited to "how not to outsource jobs" or

“how to minimize costs to employees during workplace transition,” but they must also address those areas that will lead to overall improvements in employees’ working lives. If this is not done, this case suggests that employee interest in cooperation will wane over time as their frustrations increase and inevitably will result in the dismantling of the joint initiative.

The parties were unable to balance conflict with cooperation.

In all labor-management relationships, there are always integrative as well as distributive issues with which the parties must deal.³⁰ A key to maintaining cooperative relations is the successful balancing of cooperation and conflict.³¹ Rather than be thought of as two ends of the same continuum, the two are best thought of as two separate dimensions. As it turned out in the Twin Cities case, conflict eventually overwhelmed the cooperative aspect of the relationship. The 2001 contract negotiations proved to be highly divisive, ending with nurses’ anger directed towards both management and the MNA.

The issue of staffing was of central importance during the 2001 contract negotiations. MNA-represented nurses in the Twin Cities felt strongly that they needed increased say over workloads. They felt they were chronically short staffed, that short staffing was hindering their ability to deliver safe and effective care, and they perceived that management was deaf to their complaints regarding the nursing shortage. Nurses were further angered by management as the strike deadline loomed closer and management set about making contingency plans in case of a strike, including contracting for the services of hundreds of replacement nurses from out of state. Whether or not these replacement nurses would be used, management nonetheless would have had to expend considerable sums of money—money that otherwise might have been used to alleviate, at least in part, the staffing shortage nurses faced on a regular basis.

Coupled with their anger at their employers, nurses also became increasingly frustrated with their union. As nurses at each individual hospital voted whether or not to accept the contract negotiated there, the MNA was responsible for counting votes and determining whether the contract was ratified or not. A miscount at one hospital—where nurses had in fact voted by one vote to reject the contract but the MNA mistakenly accepted on their behalf—began a movement for the recall of the leadership of the MNA. MNA leadership was accused of being irresponsible and unresponsive to the issues and needs of the nurses it represented.

Ironically, when the strike at two Twin City hospitals was over, part of the settlement mandated that joint committees address hospital unit staffing patterns and methods to ensure that adequate staffing was put in place. Even while labor-management cooperation was in crisis, unit-based cooperation was adopted to address nursing staffing issues. Moreover, several hospitals formed specific cooperative committees to address the broad issue of nurse staffing. However, the potential for these mechanisms faced large hurdles. Trust in the cooperative process was severely damaged. The 2001 conflict clearly overwhelmed cooperation and many nurses had lost faith in their union leadership.

It is an open question whether cooperation can be re-established in these circumstances.

This loss of cooperation due to the spiking of conflict is far from unusual. Twenty years ago, this phenomenon was documented at a Rath meatpacking plant.³² Labor-management cooperation went through several cycles of on-again, off-again relations, finally ending with the dissolution of all cooperative undertakings as conflict consumed the relationship. In some cases, however, conflict can be pushed aside and the cooperative venture can be saved. In the early 1980s, as General Motors and the UAW were first engaging in cooperative efforts, GM began opening a number of nonunion plants in the South. GM's Southern Strategy was deemed unacceptable to the UAW if the company wished to continue to enjoy cooperative relations and the tangible benefits of cooperation in its unionized plants.³³ In this case, however, the company backed down, agreed to neutrality with respect to the organization of its Southern plants, and cooperation with the UAW continued.

In part, realizing that conflict does not go away when parties enter into cooperative undertakings is a large step towards managing the tensions that inevitably arise. Union representatives and managers must realize that the existence of cooperation does not eliminate conflict. Further, they need to know that conflict is not pathological, but rather is a natural outcome of such a relationship.

Conclusion

While research on labor-management relations has found that cooperation can yield a set of valuable outcomes for both employees and organizations, there remains a lack of long-term, successful cooperative efforts in the United States. Since formal labor-management committees are not legally mandated in the U.S., the competitive demands facing the organization will greatly influence both the desire to adopt cooperative relations as well as the capacity to maintain them.

As noted, there are four challenges inherent in cooperative undertakings that can contribute to their demise. First, the constraints imposed by cooperation done across multiple sites limit the topics of discussion or potential solutions to problems raised. These constraints are exacerbated by the volatility of the environment. Second, the institutions of cooperation are static and have difficulty evolving to meet shifting issues, contexts, or problems. Once the parties have dealt with the original problems for which the institutions were designed, cooperation often falters because of a lack of any evolution in the structures. Third, employees may eventually turn on cooperation, blaming it for anything that displeases them at the workplace. Expectations about what cooperation ought to deliver often far exceed reality. In addition, the outcomes of cooperation can be disappointing as the parties merely lessen negative impacts rather than provide upside benefits. When expectations are not met, cooperation is blamed. Fourth, cooperation seems extremely vulnerable to any conflict in the rest of the

parties' relationship. Unable to separate these two discrete dimensions, labor and management often end up using cooperation as the hostage, withdrawing from cooperation to punish the other side for its escalation of conflict.

Previous theories have hypothesized that labor-management cooperation emerged in response to economic cycles—either when labor's power increased as a way to reassert managerial control³⁴ or as a way to gain worker commitment to achieving management's competitive objectives³⁵—and then dissipated when those conditions were no longer present. The Minnesota case shows that labor management cooperation arises under both conditions—the mid-1980s financial crisis coupled with the increased power of the MNA coming off a highly successful strike forced the parties to engage in massive, systemwide restructuring through labor-management cooperation. However, despite similar conditions re-emerging in the 1990s as the nursing shortage wreaked financial havoc on employers and gave additional leverage to the MNA, labor-management cooperation at that time faltered and fell apart.

The two theories presented earlier each specify different drivers of the rise and decline of labor-management cooperation. In part, the differences in predictions from these two theories stem from the specific contexts from which the data used to construct each theory were collected. Ramsay's argument is based on evidence from the United Kingdom where labor traditionally enjoyed greater strength and was far more militant than in the United States.³⁶ Barley and Kunda's argument, in contrast, is based on data from the United States—a much different institutional context where organized labor is much weaker and management enjoys a virtually unfettered hand in workplace decision making.³⁷ These two theories provide little in the way of actual micro-level mechanisms by which cooperation comes about and, more importantly, comes apart. Labor-management cooperation does not decline solely in response to external forces as others have argued, rather, it is also vulnerable to the challenges it faces from within.

The Minnesota case combines the two contexts in which each of the previous theories has been developed. In this case, there were pressures from *both* labor and management *both* to cooperate and to end cooperation. The mechanisms underlying the premature demise of labor-management cooperation provide clues as to when certain challenges are likely to be most salient. For example, the volatility of the competitive environment appears critical in precipitating two of the four challenges highlighted in the Minnesota case. Not only did multi-employer cooperation become very difficult to manage in the context of changing markets and competitive strategies, but also the institutions of cooperation needed to evolve over time to deal with new issues that occurred at different levels in the organization. At the same time, changes in the power of labor also raised two of the other significant challenges for managing labor-management cooperation over the long term. A well-organized union run with highly democratic practices has the power to actively cooperate with management and bring the views of its members to the negotiating table. Similarly, a strong union that disagrees with management in other areas of the relationship

may unilaterally withdraw from cooperation and revert to a more traditional adversarial relationship.

Nevertheless, despite the recent demise of cooperation in the Twin Cities, the benefits accrued to both hospitals and unions from the early 1980s are clear: through a cooperative process, hospital managers and MNA representatives successfully restructured hospitals and patient care delivery while maintaining the interests of the hospitals and the union's members. Moreover, with the completion of the most recent negotiations, joint union-management structures have begun to reappear within individual hospitals to deal with conflicts over nursing workloads, signs that cooperation may reemerge as hospitals and unions address a new set of challenges.

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