The Challenge to Change

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The Political Impulse for Change in the United States

Between the 1970s and the 1990s, managed care came to dominate the American health care landscape. Medicare and Medicaid covered the older and poor populations, respectively, and most Americans received health insurance through their employer or the employer of a family member. The number of uninsured people, however, rose steadily from the 1970s to the 1990s (Gilmer and Kronick 2001; Kronick and Gilmer 1999). Rising health care costs and the increasing number of uninsured people were a major issue in the 1992 presidential election, when Bill Clinton, running against the incumbent President George H. W. Bush, vowed to bring sweeping health care reform to the country, if elected.

Bill Clinton’s 1992 presidential campaign initially focused on vaguely formulated ideas about health care reform, such as guaranteeing health care security for all (Hacker 1997; Skocpol 1995). Paul Starr, the sociologist who became part of Clinton’s health care reform team, argued that “uncontrolled
growth in costs and deepening insecurities about insurance are not only problems in health care; they are also an index of political failure” (Starr 1994, 27). Working with a team of political advisors and policy experts, Clinton gradually refined the reform proposal to emphasize “regional insurance purchasing agencies along with modest new tax subsidies to push the employer-based U.S. health care system toward cost efficiency and universal coverage” (Skocpol 1995, 69).

Clinton’s plan of increasing regulation to foster “managed competition” was a kind of middle ground, ostensibly designed to rein in costs without creating undue government interference either in health care markets or employee benefits decisions. Once in office, President Clinton appointed his wife, Hillary Rodham Clinton, to lead the White House’s effort to reform health care as the head of a twelve-person task force. Because this followed closely on the heels of the three-way presidential election focused on the problems caused by the budget deficit, balancing the budget was a key priority. It seemed politically impossible to propose a health care reform package that would increase deficit spending, so the Clinton plan focused on increased coverage paired with cost control. These themes re-emerged in President Barack Obama’s plan for health care reform during and after the 2008 presidential election.

Hacker (1997, 171) argued that “Clinton and his advisers embraced managed competition within a budget precisely because they believed that it stood a better chance than other comprehensive reform proposals of surviving the American political gauntlet.” Another factor diminishing the chances of the proposal’s success, according to Gottschalk, was division within organized labor, especially the ongoing debate over whether single-payer or an employer mandate was the solution, and this gave labor an inability to provide practical policy support to Clinton (Gottschalk 2000, 137–58).

The great irony of the failed Clinton reform is that it gave birth to a boom in managed care, without the attendant employer mandate that might have increased access and slowed the rise of the uninsured. Both before and after the Clinton reform effort, the political wrangling successfully illuminated many key problems with the health care and health insurance systems, but it failed to solve these problems. This spawned an industry of consultants and credentials, profiting from the sale of performance-improvement strategies to health care providers. These initiatives ranged from Magnet Hospi-
tal Status (first awarded by the American Nurses Credentialing Center in 1994) to the multibillion-dollar health care management consulting industry, which is growing at a rate of almost 20 percent a year (American Nurses Credentialing Center 2014; Sager 2013). From 1993 to 1996, the number of Americans whose health insurance was delivered through health maintenance organizations (HMOs) jumped from 21 to 31 percent of those with employer-sponsored insurance (Henry J. Kaiser Family Foundation 2005). The number of Americans now enrolled in HMO-based health care through Medicare, Medicaid, or employment-based insurance is around 75 million people and rising, according to the latest available data (Henry J. Kaiser Family Foundation 2015c).

Some of the oldest HMOs, such as Kaiser Permanente and Group Health of Puget Sound, are nonprofit organizations, but others are not. Some scholars have debated whether one form of ownership or another is more beneficial to either high-quality care or cost control. Some argue that the profit motive promotes competition and cost control; others argue that not-for-profits can focus on high-quality care without excessive emphasis on cost cutting. Robert Kuttner argued in 1998 that “one of the original promises of prepaid group health was to improve coordination of services. It is ironic, then, that despite a lot of talk about ‘virtual staff models,’ many nominal HMOs today are actually far-flung assortments of doctors with strict utilization controls or financial incentives but little ongoing interaction, much less a common approach to practice. For-profit plans are leading this trend, but some nonprofit plans are following suit because of competitive pressures” (Kuttner 1998, 1562). Although Kuttner made the observation over a decade ago, it is even more applicable today.

By the end of the Clinton presidency, it was clear that the health care crisis was only growing worse. Blumenthal (1999, 1916) observed that “we seem to be wrestling with many of the same health policy demons that occupied us in 1994 and, indeed, for thirty years before that: the large and growing number of uninsured Americans, the high overall costs of our health care system, and pervasive evidence of the suboptimal quality of care.” The ongoing failure of the system to provide low-cost, high-quality health care available to all continued through the 2008 election. Indeed, costs were still rising, quality was still questionable (debates over which measures most effectively capture health care quality notwithstanding), and the number of uninsured and underinsured Americans was rapidly rising.
As the health care crisis progressed from chronic to acute, health care was a dominant campaign issue in the 2008 presidential election. All the major candidates offered a proposal for health care reform. The key differences in the proposals addressed the degree of government involvement in health care insurance and the use of mandates—mandating employers to provide insurance, or mandating individuals to purchase insurance, or both. Other key proposals ran the gamut of the health care economy, from reforming tort laws in an attempt to lower the cost of malpractice insurance to regulating insurers to prohibit some of their most egregious actions. No major candidate proposed national health insurance or a single-payer or socialized system of any kind.

After taking office, Obama modified his proposals for health care reform. Opposition to change reached a fever pitch, culminating in the notorious Tea Party protests against government intervention at town meetings around the country in the summer of 2009 (Herszenhorn and Stolberg 2009; Urbina 2009). When it became clear that the Democrats could not pass a reform plan without compromise on the so-called public option, a service that would be similar to Medicare, Obama began to negotiate with the Republicans. Although Obama’s plan incorporated a number of compromises along the way, it ultimately passed through Congress without any Republican support.

In the United States, one can see the push and pull between privatization and resistance in the rejection of a single-payer option in the Obamacare deliberation process. This apparent rejection of public funding actually led to the vast majority of newly insured Americans being covered by Medicaid, a massive public program. Change from below that pushes back against neoliberalism illustrates a dynamic that repeats again and again in both the United States and the United Kingdom. In the case of Obamacare, the pendulum swung in the direction of private provision and market-based health care.

The Patient Protection and Affordability Act of 2010 was the result of Obama’s push for health care reform, passed only after protracted deal making and parliamentary maneuvers. The act was phased in gradually, with several key provisions delayed from the timelines set out in the original act. The act imposes requirements on individuals, employers, and insurance companies. Individuals must purchase insurance or pay a fine; if insurance is not available through an employer or through expanded Medicaid eligibility, they may purchase insurance through an “exchange” where private
insurers offer plans. Lower income Americans who cannot afford insurance but do not meet Medicaid eligibility requirements have access to government subsidies for the purchase of private insurance. Employers with more than fifty employees are required to offer insurance to their employees or pay an additional payroll tax. The smallest employers receive a subsidy toward the cost of health insurance. Insurers are faced with a large set of new regulations, including the inability to deny coverage based on preexisting conditions, the prohibition of lifetime limits on insurance benefits, and a mandate to provide coverage in several areas, such as preventive care and mental health (Democratic Policy Committee 2010).

The crucial element in these reforms is that they increase access to care but do not necessarily change the delivery of care once the system is accessed by a patient. In other words, they do not affect the central argument here, which is about the change initiatives that affect the way in which health care is delivered. The key challenge to frontline health care providers will be to increase the capacity of the system and to contain costs (a much vaguer goal of the act). The actual mechanism for increasing capacity and containing costs is not fully specified (with the partial exception of the incentives provided for accountable care organizations and medical homes), so the power of consultants and changes pushed from above remains untrammeled (Sager 2013).

Restructuring in the United Kingdom

The basic structures of the NHS remained generally unchanged from the service’s founding until the Thatcher governments of the 1980s. From the Thatcher era to the present, the major exception to this has been in the area of pay, which has been the subject of repeated attempts at restructuring (and attacks on collective bargaining). The NHS had always been highly centralized, but Thatcher’s Conservative government strongly advocated decentralization across the public services. The major change under Thatcher was the creation of self-governing NHS trusts with some autonomy over organizational decisions. Staff within these trusts were then officially employed by their local trust, although most remained on nationally determined terms and conditions due to the strength of their unions, which were strongly opposed to local pay (Maynard 1991). The increased autonomy for local
employers allowed more flexibility for hospital management, and some used this freedom to attempt massive new change initiatives.

The development of health care reform policy in the United Kingdom involves a complex configuration of interests at the national level. The party in power has the primary ability to introduce legislation, and the British electoral system ensures that almost all the legislation originating with the government will pass.\(^1\) All the ministers and the secretary of state are appointed by the prime minister and may be reshuffled out of the position at any time. The prime minister therefore has the power to set the policy agenda and ensure that bills are passed.

The types of reform conducted by the government can be divided into two main categories: legislated changes and regulatory changes. Regulatory changes do not necessarily require legislative approval and may include some forms of internal NHS reorganization as well as changes to the systems of audit and monitoring, which do not alter financing arrangements or governance structures. Policies that affect only terms and conditions of employment can be negotiated directly (on a tripartite basis) among the Department of Health, the NHS employers (represented by the NHS Confederation), and NHS employees (represented by more than twenty officially recognized unions). Unless the scope of the policy broadens, these regulatory changes do not need to pass through Parliament. Wider-ranging reforms, such as changes in the institutions of hospital accountability and governance, must pass through Parliament; the most recent significant example of this is the Foundation Hospitals Bill establishing a new form of quasi-autonomous NHS hospital (Department of Health 2002b).

In recent years, NHS funding has increased sometimes, particularly expenditures targeted at reducing waiting lists and addressing the shortage of nurses. The government ultimately determines the pay increase given to nurses and doctors each year, after a recommendation from the Pay Review Body, which in turn receives submissions from all the key stakeholders such as the government and the unions. Because the NHS is the largest employer in the United Kingdom, NHS wages are often constrained by the government’s need to set a cautious wage pattern and to keep inflation in check.

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1. Other MPs can introduce legislation, known as a Private Member’s Bill, but these bills rarely pass.
With the notable exception of organized patient groups, the key stakeholders in health care have remained relatively stable in Britain. These organized interest groups have been forced to respond to restructuring initiatives aimed at increasing capacity and improving efficiency, frequently through the use of outsourcing and novel forms of financing and subcontracting. The restructuring of the NHS does not threaten the overarching model of a national single-payer system in which services are free at the point of use. Rather, the key reform initiatives are clustered around efforts to increase auditing and monitoring to measure (and incentivize) good performance and efforts to restructure the delivery of care to improve the patient experience while providing individualized services with better clinical outcomes. These two sets of initiatives reflect the same trends as the restructuring efforts in US hospitals.

Pay systems in the NHS have changed fairly dramatically in the last few decades. Doctors are still paid at collectively bargained rates. Other NHS staff have had nationally imposed pay levels, subject to consultation but not negotiation with the unions. These pay reforms (ultimately pay increases, although sometimes at constrained rates) have cost the NHS about £540 million (around $750 million) above the projected budget (Buchan and Evans 2007, 9). This pay reform, designed to accompany the restructuring of job roles and to more accurately reflect employee knowledge and skills, has been extremely expensive.

The most recent example of the restructuring of pay came under the Agenda for Change (AFC) project, which required the creation of new job profiles and pay for all directly employed NHS staff with the exception of doctors (Department of Health 2003a). This agreement was negotiated with all the recognized NHS unions (twenty-four in total at the time) affected by the restructuring. The project entailed regrading staff according to specific skill and job profiles, rather than less accurate job titles. One impetus was the rise in pay discrimination claims that resulted from the gender stratification of the lower skilled occupations in health care. Negotiations over AFC lasted almost three years, and several unions (notably Amicus, the Society of Radiographers, and UNISON) expressed serious reservations with the final

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2. As of this writing, this pay system is still in place.
agreement. The attempt to negotiate rather than impose change made the process much more protracted (Department of Health 2003a, 2004a; Royal College of Nursing 2003).

The evolution of AFC illustrates the difficulties of moving from policy creation into policy implementation. Although the need for some form of pay restructuring was recognized by political leaders, civil servants, and the unions, the human resources directors in the hospitals expressed deep reservations about the complexity of the new system. Much of this concern derived from the institutional memory of the previous experience of pay restructuring under the Thatcher government, which was both protracted and contentious and resulted in a system of pay and grading that was widely considered suboptimal. As one senior civil servant put it, this attempt at pay modernization “failed quite badly” (personal interview 2002). The implementation process of AFC was on a case-by-case basis, with all positions evaluated against model job profiles to determine the correct grading (and therefore pay) for any single job. Although job evaluations were supposed to be conducted in partnership between unions and hospital management, the unions also took on the role of monitors to ensure that all staff were treated fairly by their employers. Assessment of the impact of AFC has been sparse, although early findings suggest that workplace managers appreciate the new framework, while individual employees have experienced little progress (Buchan and Evans 2007). As of this writing, the AFC framework still determines pay for most NHS employees (NHS Employers 2014).

In 2003, just as the protracted AFC negotiations were reaching agreement on a new pay structure for nonmedical staff in the NHS, the government was also negotiating a new collective bargaining agreement with doctors—specifically the consultants, the 30,000 senior doctors whose professional expertise and key role in service delivery gives them leverage disproportionate to their numbers in the workforce. In 2002, a proposed consultant contract was rejected in its ratification vote by the British Medical Association. This was the first major (proposed) change to the collective bargaining agreement since the founding of the NHS in 1948. The rejected contract offered generous pay raises in return for greater managerial control over doctors. As an editorial in the British Medical Journal explained,

It was rejected primarily because it gave more control to managers, people who in many hospitals are neither trusted nor respected. This might be seen
as a simple power struggle, with consultants refusing to be told what to do. Why shouldn't they get into line like most other workers?

All consultants work in teams, and most recognize that they are part of complex organizations and need to play their part. . . . Hospitals handed over entirely to managers and politicians will, consultants believe, be less responsive to patients’ needs. Many managers believe the opposite. What’s clear is that the NHS will not flourish unless doctors, managers, politicians, and all other staff can work well together and pursue the same goals. But perhaps this is best achieved by giving considerable autonomy to consultants. Most, after all, have done more than they are required to, even though some have abused their privileges. Consultants must accept, however, that managers play a vital role in complex organizations like health care. The beast will not run itself. (Smith 2002)

The final consultant contract, negotiated a year later, dropped many of the areas in which doctors would have ceded some control over their schedules and work organization, while retaining the generous pay increases. This affirmed the powerful role of doctors in constraining attempts at work reorganization, Maynard and Bloor argued. “Temporarily at least, the demand for clinical autonomy . . . has triumphed. At the same time, the personal income of consultants has been substantially enhanced” (Maynard and Bloor 2003, 5).

One major element of health service reform has been the growth of performance targets and indicators, particularly since the election of the Labour government in 1997. The central element of monitoring and audit of the NHS is a complex system of performance indicators. Many of the targets were informed by political considerations, in particular the Blair government’s early promise to significantly reduce waiting lists for NHS treatment (Labour Party 2001). Although the targets were formulated to meet political (and electoral) objectives, the tasks of meeting and administering them fell to civil servants in the Department of Health and to health service managers in hospital workplaces. The targets are designed as both drivers and monitors of good NHS performance (personal interviews 2002). The performance indicators were nominally implemented, often in ways that produced dramatic, unintended consequences (Givan 2005).

As systems of measurement and monitoring arose in the United Kingdom, prominent scholars began to question their value. In The Audit Society, Michael Power (1997) argues that the culture of monitoring in the public
sector is part of a larger move toward asserting centralized control. By holding local managers to so many detailed and specific standards, the government retains control over the service while still adhering to the principle of local autonomy and decentralization. Julian Le Grand (2003) argues that the imposition of greater monitoring is a symptom of a move away from regarding public service professionals as generally altruistic, possessed of a specific ethos that drives high-level performance. In the case of the NHS, local hospital trusts are told which goals they must meet, but they are (theoretically) free to determine how best to meet these goals. The dynamic of power and accountability is crucial in determining whether a policy is successfully implemented or whether local managers and frontline service providers resist or reshape the change. Where local managers feel that they have been neither consulted nor involved in the creation of the performance indicators, they are unlikely to implement them in the way intended by the original policy. As such, the government is not able to enforce policy implementation, even when it attempts to impose stiff penalties for noncompliance.

Many of the target areas in the NHS performance ratings are based on political point-scoring of the past (Hansard [Commons] 2002a, 2002b). In the United Kingdom, the opposition party traditionally has mocked the government for the length of NHS waiting lists. Unlike many aspects of health care, waiting lists are easily measurable and quantifiable. Waiting list data are easily comparable, and it is therefore fairly straightforward to track increases or decreases in the times patients wait to see a specialist doctor or the time they wait for a particular procedure. Although the Labour government successfully increased the size of the NHS workforce in order to reduce waiting lists, both new and existing staff had to embrace the “new ways of working” put forward by the government if greater efficiencies were to be realized. The waiting list targets were formulated by the government (with many of the deadlines designed with an eye to the electoral calendar), but these politicians could not ultimately determine whether the targets were met. Perversely, the pressure from the government on the workforce led to allegations of gaming the system and cheating among NHS managers (Public Administration Select Committee 2003).

The dilemma of decentralization is that if the government diffuses control, it gives up its ability to determine outcomes; but so long as the government is held politically responsible for these outcomes, it cannot completely cede control of the NHS—hence the prevalence of targets and systems of
audit. Many health service managers felt seriously constrained by the national policies and targets because these are, by nature, not sensitive to the particularities of the local context (Givan 2005). Similarly, members of Parliament (MPs) were frustrated when hospitals were not meeting the needs of the population they were supposed to serve. For example, one MP pointed out that when there was no government target measuring the length of the wait for a hip replacement, this procedure was not prioritized by the trusts (in fact, this particular distortion of priorities was a major concern for one of the MPs I interviewed who represented a constituency with a large elderly population). In areas with a high proportion of elderly residents, this is a crucial service, but trusts are unable to prioritize a service of particular local importance such as this without failing to meet other targets and risking the imposition of punitive measures (and without their top managers risking unemployment due to poor performance). The system of incentives and penalties concomitant with NHS performance ratings makes it impossible for a trust to abandon the government’s list of priorities and create its own priorities based on local needs.

The target-setting culture that pervaded the Labour reform agenda came under extensive criticism from the Audit Commission, a national (governmental) budget and expenditure watchdog, the House of Commons Public Administration Select Committee, and the major health unions (Audit Commission 2003; Public Administration Select Committee 2003). The combined criticism from employee groups and monitoring bodies illustrates the serious shortcomings of the target-based approach, though none of these groups had the power to alter the procedures. The implementation of the policy was so inconsistent that it never met its original objectives, and it has been under constant revision by the government and its agencies ever since (Healthcare Commission 2004). My interviews with workplace managers revealed both manipulation of data and extreme suspicion about the reliability of certain statistics (Givan 2005), so the workplace implementation of these procedures has been a far cry from the policy as originally designed.

The NHS was originally a unitary system, with almost all services owned and operated by the NHS itself and all staff directly employed. The only major exception was general practitioners, who were independent contractors. In a typical hospital, however, everyone from a consultant (attending physician) to parking attendants, maintenance staff, and technical specialists were all government employees. This employment status included
national terms and conditions of service, national pay systems, and a relatively generous government pension.

Around the mid-1980s some NHS services were subcontracted to the private sector, as Thatcher imposed competition and subcontracting across the public services (Boyne 1999). The services were similar to the work many companies subcontract, in areas such as cleaning, catering, and payroll. Since it began in the early 1990s, the use of temporary agency staff in the NHS has also increased markedly. This is especially true in nursing, where agency nurses achieve higher wages and greater flexibility in return for minimal benefits (Tailby 2005). The outsourcing of support services seems to have stabilized and stopped increasing, and there is even some evidence that providers are now in-sourcing these services, thus returning them to in-house provision by direct hospital employees (Bach, Givan, and Forth 2009).

As part of its reform agenda, the Labour government also made a commitment to diverse forms of financing of public services. This included using both private sector funding and private service providers. One of the major aspects of this reform is the Private Finance Initiative (PFI). Through PFI, private companies or consortia design, build, finance, and operate public service facilities such as schools and hospitals under a long-term (usually between twenty-five and sixty years) contract from the public sector. The main innovation in these schemes was the form of financing and the degree of control the private company had over the form of services provided. Many trade unions remain vehemently opposed to PFI on the bases that it provides inferior services and that profiting from public services is inherently wrong.

Other examples of the mixed economy of health care include the Diagnostic and Treatment Centers (akin to ambulatory clinics in the United States), many of which are operated as public–private partnerships. Similarly, to cut waiting lists in the NHS, some patients are funded to receive private treatment, either in the United Kingdom or abroad. The New Labour argument was that the market and competition should be used to provide public services where most appropriate and practical, rather than being ruled out for ideological reasons (Brown 2003). Employee groups have long argued that the growing use of private service companies to provide elements of health care is detrimental both to employees and to service users (GMB 2002a; UNISON 2002a, 2002b).

As well as subcontracting of employment, the government also adopted more sweeping programs to allow private-sector providers to operate NHS
facilities at a profit. The services at these facilities remain free at the point of use, and to the patient they should be indistinguishable from any other NHS facility. The contractual arrangements at PFI hospitals and Independent Sector Treatment Centers (ISTCs) are quite complex. In the case of PFI hospitals, a private company (or usually a consortium of companies) is contracted to design, build, maintain, and operate a new hospital. The program is usually used to provide a new building for an existing, aging hospital. The company receives a long-term contract (generally thirty to fifty years) to build and manage the facility. Once the hospital is built, the private provider is responsible for the provision of the nonclinical services. The support staff are usually direct employees of the consortium, while the doctors, nurses, and other professionals remain NHS employees. The consortium receives a guaranteed annual payment for the duration of the contract.

Public sector accounting provides the main argument for PFI hospitals. By spreading the cost of a new facility over several decades rather than paying all the capital expense at once, public-sector spending does not rise dramatically in a single year. The policymakers behind PFI also argue that they are able to transfer much of the risk to the private consortium—if unexpected expenses arise, they fall to the private sector and not the public purse. As should be evident, these PFI hospitals create myriad new employment relationships that demonstrate that the NHS is no longer a unitary employer. Indeed, with the complex negotiation on behalf of support staff working in PFI facilities, those staff who were employed by the NHS are able to remain employed by the NHS, while new staff in certain jobs such as cleaning are employed by the consortium. This leads to the so-called two-tiered workforce, in which workers in the same job at the same facility may be subject to radically different pay levels and terms and conditions of employment (Bewley 2006).

Several large unions have opposed this so-called creeping privatization in principle, but in practice they have taken a more pragmatic approach. My workplace interviews revealed that private providers are not always inferior employers. In fact, strong service agreements can protect employees from budget cuts, layoffs, and work reorganization. Case study research shows that the implementation of various forms of outsourcing is highly uneven, with some contractors exploiting their employees and others essentially conforming to NHS standards of employment conditions (Bach and Givan 2010; Givan and Bach 2007).
In 2012, the Health and Social Care Act implemented by the Conservative government laid the groundwork for another cascade of changes in the UK system. This act has the potential to reshape the NHS because the power to “commission” health care has been placed in the hands of general practitioners, who vigorously fought change. Thus far, dramatic changes resulting from this act have not emerged; in fact, the effects of this act have been dwarfed by the cost pressures created by massive government cuts to the NHS. On the potential effects of the 2012 Health and Social Care Act, one report stated that “the NHS has proved to be remarkably resilient in the face of efforts by successive governments to make major changes in how it is run and there is no reason to expect things to be different this time round” (Timmins 2012).

Conclusions

Neither the US nor the UK health care system is necessarily currently at a major turning point, but they are in a process of constant change. The Health and Social Care Act of 2012 set the stage for increased private provision in the NHS but only built on the reforms of the New Labour government, which in turn had continued the process of change handed to them by the previous Conservative government (Peedell 2011). While the Conservative-led government in the United Kingdom and the Obama-led health care reform act in the United States might seem to be ushering in an era of change, this constant evolution is nothing new. Change initiatives have come to these systems from all directions and at all levels. Cost pressures in both countries have increased. While expenditures on health care have increased, so has the pressure to provide high-quality care at the lowest possible cost. In both countries, mandatory and voluntary regulators have imposed a bewildering array of standards and metrics, requiring hospitals to both change their procedures and measure their outcomes. The patient-safety movement has reached hospitals in both countries, bringing pressure to both track and reduce errors. New trends such as patient-centered care have pushed providers to reorient their work, in this case to focus clinical care around the needs and decisions of the patient rather than around organizational efficiency or physician control.
In spite of the differences in the systems in access to and payment for health care, hospitals in both countries confront similar attempts at change, often with similar outcomes. The effects of these attempts at reform reveal a decidedly mixed bag. When providers decide to flex their muscle, they are able to determine the direction of change, as illustrated by the negotiations over pay reform. There have been many changes in the past decade, however, primarily in the interest of increasing both the capacity and the quality of the health service. These changes have had a huge impact on the health service employees who must implement the changes and live with the consequences. I will demonstrate in the chapters that follow how the complex dynamics among doctors, nurses, workplace managers, and higher level decision-makers create a tangled web of interests in which change is slow and difficult and frontline health care staff play a critical role.