Editor’s Introduction
Introduction to a Symposium on the Kaiser Permanente Labor Management Partnership

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Industrial relations researchers have historically been diligent in analyzing the most important and visible cases of labor management innovation of their time. Examples of such analyses include studies of labor management cooperation in the 1920s (Harbison and Coleman 1951; Slichter 1941), the TVA (Selznick 1984), the west coast mechanization and modernization agreement (Hartman 1969), the Armour Automation Commission (Shultz and Weber 1966), NUMMI (Adler 1993), and Saturn (Rubinstein and Kochan 2001). These cases were never presented as representative of collective bargaining or industrial relations developments of their time but as images of what was possible to achieve when necessity and leadership combined to respond to a critical problem or challenge of the day. These leading cases thus stretched the thinking of researchers, practitioners, and policy makers about what collective bargaining might be capable of doing if given the opportunity and necessary support. It is in this tradition that we present three papers describing and analyzing a decade of experience under the Kaiser Permanente Labor Management Partnership.

In 1997 Kaiser Permanente, the nation’s largest private integrated health insurance and health care delivery organization, and a coalition of ten national and thirty local unions signed an agreement to create a labor management partnership. Over the past decade it has grown to become the largest, and as will be described in the papers in this symposium, the most ambitious labor management partnership in the history of U.S. labor relations. Since 2000 our research team has studied the partnership through interviews, surveys, case studies of specific projects, and participant observation of national contract negotiations.

The papers presented in this symposium report on three aspects of our research that capture critical challenges and opportunities facing labor, management, and government policy makers today. The first paper focuses on the partnership as an exercise in organizational change and governance,

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noting the precariousness and the potential of this type of ambitious effort. Labor management partnerships have waxed and waned over the long history of U.S. industrial relations. Yet we have little theoretical understanding of how they actually work. This paper therefore explores the strategic and organizational challenges experienced in labor management partnerships, in order better to understand the role these partnerships currently play—and the role they might play in the future, if they were supported by national policy makers and labor and management leaders.

The second paper takes advantage of the unprecedented access our team was afforded to observe the parties’ 2005 contract negotiations to describe and analyze how a mix of traditional and interest-based negotiations processes played out as the parties’ bargained a new labor agreement. Interest-based bargaining has spread rather stealth-like to perhaps as many as half of the collective bargaining relationships in the country. Yet we have relatively few studies of how the tools of interest-based bargaining modify either traditional bargaining practices or traditional bargaining theory. We use the data gathered in these negotiations both to describe and to analyze how interest-based bargaining interacted with conventional distributive, integrative, intraorganizational, and attitudional dimensions of the bargaining process.

The third paper analyzes the dynamics of the union coalition as it engaged in both the negotiations process and in the ongoing partnership over this first decade. We situate this paper in the contemporary debates over the appropriate structure and interrelationships among American unions and in the literature on the challenges for unions in partnering with management. The Kaiser Coalition came together under the auspices of the AFL-CIO and consists of unions that continue to be part of that federation as well as unions that are now part of the Change to Win Federation and an independent union. A major union, the California Nurses Association, represents approximately 11,000 Kaiser Permanente nurses and has chosen to not join the coalition or participate in the labor management partnership. As such, the dynamics of the coalition at Kaiser-Permanente serve as a microcosm of the strategic and structural challenges and choices facing the American labor movement today.

We hope these papers provide a window on this current effort to push forward the frontier of labor management relations. While we recognize the limits on generalizing from any case study, and especially one as complex and unique as the one presented here, we also see the Kaiser Partnership as an important historical marker, one that labor, management, and government leaders might use to ponder and debate how collective bargaining could be adapted and more fully exploited to address the critical challenges facing contemporary industrial relations.
In the remainder of this brief introduction we will summarize the history of Kaiser Permanente, the broad features of the partnership, and some of its achievements and limitations to date so that the individual papers can focus more directly on the analytical and theoretical issues of interest.

Kaiser Permanente Health Care

Kaiser Permanente (KP) is America’s largest private integrated health maintenance organization (HMO) and hospital and health care delivery system. While 80 percent of its operations are in California, nationwide it serves 8.6 million members across eighteen states and the District of Columbia.

In 1933 Henry Kaiser asked Dr. Sidney Garfield to provide health care to the 6500 workers and their families engaged in building the Grand Coulee Dam. Together they created the nation’s first pre-paid group health care practice and insurance program. During World War II Kaiser and Garfield, together with the unions representing blue-collar workers, formed an association to provide health care to Kaiser’s expanding steel and shipbuilding businesses in California. Shortly after the war, the plan gradually expanded, in large part by adding other union health plans to its customer (they call their customers “members”) list. Union pension funds loaned Kaiser money to build the first Kaiser-owned hospital. In 1952 the organization was named Kaiser Permanente and split into a partnership between two organizations: (1) Kaiser Foundation Health Plan and Hospitals, and (2) Permanente Medical Groups. The latter is composed of the physicians and related health care providers while the former, as the name suggests, is made up of the HMO insurance plan and the hospitals owned by the group. Permanente’s various medical groups operate as for-profit organizations contracting services solely to Kaiser health plans and hospitals. The health insurance and hospital components of KP have retained their non-profit status.

KP workers (including nurses, technical workers, and service and maintenance as well as many clerical workers) were unionized shortly after the non-profit organization was created. Today KP employs approximately 111,000 workers, of whom about 100,000 are represented by unions. Since KP’s operations are highly decentralized, prior to the labor management partnership agreement collective bargaining took place separately with more than thirty different local unions and bargaining units, each of which was then governed by a separate contract with different expiration dates. In 1995, twenty-six of the unions representing Kaiser employees met and formed the Coalition of Kaiser Permanente Unions (CKPU). Approximately 86,000 workers are currently represented by the coalition unions.
In October 1997 KP and the CKPU signed an agreement to enter into a comprehensive labor management partnership. Figure 1 lists the key provisions in the partnership agreement. Its seven objectives illustrate the partnership’s broad scope including concerns for improving the quality of health care, expanding KP membership and market share, and improving its performance as well as key employee and union objectives of providing job security, making KP a better place to work, and involving employees and union leaders in decision-making.

The partnership structure is depicted in Figure 2. The top two dotted boxes represent the two separate governing bodies for KP and the unions: the Kaiser Permanente Partnership Group (KPPG) and the CKPU. The KPPG is made up of the top officers of the two parts of KP, the Permanente Medical Groups and the Health Plan and Hospitals Corporation. The Executive Director of the CKPU sits on the KPPG as an informal member. The National Labor Management Partnership Strategy Group (known as the Strategy Group) is the top joint governing body, co-chaired by the union coalition’s executive director and a KP representative. A staff organization, the Office of Labor Management Partnership (OLMP) reports to the co-directors. The National Partnership Council (see Figure 2) meets quarterly and brings together several hundred union and management officials to hear and give reports and to enhance coordination across the KP organization. Joint governing councils exist within each of KP’s regions and oversee partnership activities within their geographic areas.
Overview of Partnership Outcomes, 1997–2005

The signal achievement in the first five years of the Partnership was the successful use of interest-based bargaining principles and tools to negotiate a system-wide five-year collective bargaining agreement. Other achievements included use of partnership principles and processes to open Southern California’s Baldwin Park Medical Center in record time, and to restructure and dramatically improve the performance of the Optical Laboratory in Northern California. In addition, by 2003 the parties had put in place a range of partnership governance structures and processes and had trained hundreds of union and management leaders in partnership principles and skills, agreed on specific performance targets, and implemented partnership projects in numerous work sites.

In more recent years, the parties expanded, deepened, and strengthened their partnership, particularly among national level labor, management, and physician leaders. Some of the major achievements in the 2002–2005 period include:

![Figure 2: The KP Partnership Structure](image)
1. A number of joint efforts successfully addressed serious financial crises and budget problems that arose as a result of unanticipated membership declines in several regions.

2. The number and range of partnership projects in different regions expanded to approximately 145 by the end of 2003 and continued to grow throughout 2004 and 2005.

3. The number of employees actively involved in partnership activities continued to grow. The most recent data (end of 2005) indicated that 39 percent of employees were involved in some way, an increase from 22 percent in 2000.

4. There was a gradual but significant improvement in employee attitudes as measured in employee surveys. Employees who were involved in partnership activities (compared to those not involved) were significantly more satisfied with KP as a place to work and to receive health care, the amount and accuracy of information they received, their ability to influence decisions affecting their work and with their managers’ willingness to use their ideas for improving operations.

5. Significant reductions occurred in grievance rates in most regions. KP-wide, step 3 grievance rates among partner unions fell continuously from 15 per 1000 employees in 1998 to 7.1 in 2003 and 5.3 in 2005.

6. The number of union members covered by the partnership increased from approximately 58,000 in 1998 to 86,000 in 2005. These numbers included newly hired and newly organized workers as well as the addition of some existing local unions that joined the Partnership.¹

7. There was an observable deepening of support for the partnership among senior leaders of KP and the union Coalition. This was particularly noteworthy given the leadership transitions and new appointments in senior positions that occurred over this period.

8. There was continued growth in the number of union representatives and management personnel with the knowledge, skill, and motivation needed to use partnership principles and processes.

¹ For further discussion of union growth, see the companion paper on the union coalition in this volume.
In some cases leaders had made hard decisions to reassign management and labor leaders who were not able or willing to support partnership efforts.

9. The issues addressed through the partnership broadened considerably, some of which are normally reserved for unilateral management action, such as a joint marketing initiative, consultation in the appointment of senior executives, and participation by a union representative on the Kaiser Permanente Partnership Group.

At the same time, the parties had been less successful in meeting some of the partnership’s basic goals:

1. Most of the cost savings achieved by 2006 had come from one-time budget cuts involving reductions in hours or staffing (without resort to layoffs). These came largely in response to specific crises provoked by projected or actual membership declines or other unanticipated events. The parties had been less successful in translating their achievements in these one-time problem-solving efforts into ongoing day-to-day management and work processes focused on improving the delivery of health care and the quality and satisfaction of work. As a result, in most settings the partnership continued to be viewed as a labor relations initiative rather than as an operating philosophy.

2. On several national priorities, including safety, attendance, and market growth, system-wide progress was very limited, despite sometimes impressive progress in specific locations. Some initiatives had begun to emerge that promised to broaden the partnership’s impact. A new Comprehensive Safety Management Program had been launched that appeared to be designed and structured in ways consistent with national benchmarks for improving workplace health and safety. Similarly, after a slow start, a number of joint marketing initiatives had increased the membership during open enrollment periods, retained existing members at risk of switching health care providers, and gained new accounts.

3. Despite repeated efforts, the parties had yet to put in place a system for tracking the performance outcomes of partnership activities. It was still not possible to measure the return on investment, or to link the partnership to improvement in the quality of health care.
4. The intensive time and resources and numbers of people required to implement the partnership had strained union, management, and physician staffs. The capacity to engage simultaneously in partnership activities and carry out the operational responsibilities of these individuals continued to be a major concern in some regions and facilities.

5. Support for the partnership remained uneven. In both the Health Plan/Hospital (HP/H) and the Permanente Medical Federation organizations, it was strong at the national level but variable at the regional level and weaker at middle and lower levels of management. Support was stronger across the unions, but in some unions, support at lower levels was variable, reflecting continuing variation in local labor relations climate.

6. Little horizontal diffusion or learning had taken place across locations. While extensive efforts were underway to communicate project experiences in innovative ways via the partnership newsletters, staff, and website, we found little evidence of parties seeking out lessons to be learned from other sites nor evidence that a learning culture had yet taken hold across or within regions.

7. The opposition of the California Nurses Association had kept some nurses from engaging in joint efforts. For example, efforts to reduce worker compensation costs in some hospitals had been limited by the lack of participation of nursing staff.

The papers in the symposium help understand the conditions that explain this pattern of largely positive but somewhat mixed results to date. Like other partnerships, however, there is no guarantee these results will predict the future. How the partnership fares in the years ahead will depend on the ability of the parties to meet the increased competitive pressures from lower priced insurance products coming on the market and to manage their way through changes in leadership on both the management and union sides of the partnership.

REFERENCES


