Robert Post
Charles Sabel
William Simon

Draft 4

The National Healthcare Quality Act: A Legislative Proposal

The goal of healthcare is to heal. But the publication in 1999 of the Institute of Medicine (IOM) report *To Err Is Human: Building a Safer Healthcare System*,[1] together with its follow-up report two years later, *Crossing the Quality Chasm: A New Health System for the 21st Century*,[2] alerted the nation that in striving to do good, American healthcare far too often inflicts harm. The IOM estimated that between 44,000 and 98,000 "Americans die each year as a result of medical errors. . . . More people die in a given year as a result of medical errors than from motor vehicle accidents, breast cancer, or AIDS."[3] It concluded that "Quality problems are everywhere, affecting many patients. . . . [H]undreds of thousands suffer or barely escape from nonfatal injuries that a truly high-quality care system would largely prevent. . . . Research on the quality of care reveals a health care system that frequently falls short in its ability to translate knowledge into practice."[4]

---

[1] Institute of Medicine (1999). *To Err Is Human: Building a Safer Healthcare System*. Washington, DC, National Academy Press.

[2] Institute of Medicine (2001). *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC, National Academy Press.

[3] *To Err Is Human, supra* note 1, at 1.

[4] *Crossing the Quality Chasm, supra* note 2, at 1-3.

The individual ravages of medical error are, moreover, only the most visible and immediately tragic cost of our limited ability to “translate knowledge into practice” in health care. The same features of the health-care system that produce unacceptably high rates of medical error also limit our ability to reduce the costs of providing proven therapies and delay the widespread application of innovative treatments that would further reduce costs, sometimes dramatically, while improving health outcomes. A system that has difficulty learning to avoid its most egregious mistakes will also struggle to lower the costs of routine procedures and struggle still more to adopt new techniques, no matter how promising. There are no precise estimates of the efficiency losses created by our error-prone health care system. But regardless of their precise magnitude these losses are surely so large that we as a nation will not be able to provide adequate, effectively universal health care to our citizens unless it is substantially reduced. Improving the quality of our health care system is thus part of, and indeed probably a pre-condition to making that system as inclusive as we increasingly insist it be.

Experience teaches that we can do much better than we presently do. We have succeeded in improving quality and efficiency in aviation safety, in the operation of unforgiving, fault-intolerant installations such as nuclear power-generating stations and aircraft carriers, in the protection of food chains against the incursion of pathogens, in the manufacture of complex components with great precision at high speeds and, lately, in provision of educational and child-

welfare services tailored to the needs of particular groups and even individuals. Aspects of the health care system resemble each of these domains. A hospital pharmacy or a laboratory testing blood samples and have core features of a production line; an emergency room and an intensive care unit resemble carrier operations; nursing homes establish arrangements similar to those in some child welfare settings; ambulatory care clinics blend features of several of these categories, and so on. These partial analogies suggest possibilities for the transfer of proven techniques to the health care sector.

But more important than these analogies is the fact that the institutional principles underpinning improvements in quality and efficiency in these various domains, typically worked out independently in each, show a strong family resemblance, demonstrating that they are of general application. Indeed in the last decade expert observers of the health care system, often starting from different conceptual perspectives, have converged on a list of institutional requirements and design principles for quality improvement that absorbs and synthesizes the lessons of this broad and diverse experience.

Reduced to essentials the institutional requirements for quality improvement in health care—in fact, for *any* institution that learns from its mistakes how to avoid future errors while improving efficiency and speeding innovation—are these:

1. A system for reporting “incidents” or near misses (deviations from safe procedures that only accidentally did not result in accidents). Near misses are much more common than actual accidents, and therefore more revealing of the full range of systemic vulnerabilities that must addressed to obtain robust improvement.
2. A system for identifying the root-causes of errors and near misses. Accidents and near misses are often caused by faulty procedures or equipment (or efforts to work around shortcomings in these procedures or equipment). If sources of error were manifest, they would likely be addressed before becoming dangerous. But most often they are hidden and overlooked, which means that correcting them is experienced as counter-intuitive. Improvement therefore depends on constructing systems to uncover and counter the blind intuitions induced by habit and thoughtless repetition.
3. A system for formulating responses to the root causes of problems, for ensuring that these responses are effective, and for motivating the cooperation and participation of all those who will have to implement these new responses.
4. A system for sharing across institutions the reports of errors and near misses, the analyses of root causes, and the strategies for improving quality and efficiency. Sharing these data ensures that learning will proceed simultaneously in many institutional settings, so that the pace of improvement will be quickened.

Inherent in these systemic requirements are two design principles that must guide their implementation in particular cases. The first is that an institution can learn to improve its quality and efficiency only through teamwork and cooperation. Knowledge of errors and near misses is not distributed according to official rank. To the contrary, those who are lower down at the bottom of official hierarchies are those who often see most clearly what has gone so badly wrong. The same point can be made about analyses of the root causes of errors and potential errors and of ways to address them. Problems can be effectively identified and remedied only if knowledge is pooled across lines of rank and specialization.

It is not easy, especially within the medical profession, to overcome traditionally hierarchical forms of organization and thinking. But this rigid perspective must be overcome if an institution is officially to recognize the need for cooperative problem solving by encouraging cooperation and rewarding participants regardless of the discomfit their reports, analyses, or proposals may cause superiors. At a minimum, workplace arrangements can not systematically exclude whole categories of employees from participating in all forms of decision making.

Second, systems of quality improvement must themselves be regarded as just as fallible and in need of continuous correction as the institutions whose

effectiveness they are designed to monitor. This means the operation of new quality systems must be subject to a form of monitoring whose components are analogous to incident reporting, root-cause analysis, and elaboration and verification of correctives. We will see that the States and the Federal government can play an important role in this monitoring of the monitors, and in doing so contribute to the pooling of quality and efficiency enhancing knowledge across many institutions necessary if local learning is to produce substantial and rapid progress for the health care system as a whole.

We are today as a nation both close to being able to implement these changes generally in our health care system, and far from being able to do so. We are close not only in that many of the necessary ideas and operating routines for such a system are comfortably familiar, at least in a general way, but also—and much more tangibly—in that many of the necessary pieces are already under construction, sometimes in wild profusion. The United Kingdom has a large national reporting system that has captured more than two million incidents. Australia has a different incident reporting system.[5] In the United States, the Department of Veterans Affairs has one of the oldest and most advanced patient reporting systems in the nation, which was created by former astronaut and physician James Bagian and modeled after an Aviation Safety Reporting

[5] Runciman, W. B. (2002). "Lessons from the Australian Patient Safety Foundation: setting up a national patient safety surveillance system--is this the right model?" Qual Saf Health Care **11**(3): 246-51; Runciman, W. B., J. A. Williamson, et al. (2006). "An integrated framework for safety, quality and risk management: an information and incident management system based on a universal patient safety classification." Qual Saf Health Care **15 Suppl 1**: i82-i90.

system.[6] There are presently twenty-six states that mandate reporting of actual adverse events,[7] many of which draw on a list of 28 serious reportable adverse events developed by the National Quality Forum.[8] The incident reporting systems of Pennsylvania and New York are considered particularly promising. "Virtually every hospital now has some sort of a safety program as required by Joint Commission for the Accreditation of Healthcare Organizations, and many are trying to create a non-punitive environment that encourages workers to report errors and to identify systems failures."[9] The Patient Safety and Quality Improvement Act of 2005[10] provides for the development of national safety databases.[11]

---

[6] J.R. Heget, J.P. Bagian and C.Z. Lee *et al*., John M. Eisenberg Patient Safety Awards. System innovation: Veterans Health Administration National Center for Patient Safety, *Jt Comm J Qual Improv* **28** (12) (2002), pp. 660–665; K.W. Kizer, The "New VA": A national laboratory for health care quality management, *American Journal of Medical Quality* **14** (1) (1999), pp. 3–20.

[7] National Academy for State Health Policy. (2007). "Patient Safety Toolbox for States." Retrieved June 24, 2008, from http://pstoolbox.org; Rosenthal, J. and M. Takach (2007). 2007 *Guide to State Adverse Event Reporting Systems*. State Health Policy Survey Report, National Academy for State Health Policy.

[8] Rosenthal, J. and M. Takach (2007). 2007 Guide to State Adverse Event Reporting Systems. State Health Policy Survey Report,. National Academy for State Health Policy.

[9] Leape, L. L. (2008). "Scope of problem and history of patient safety." Obstet Gynecol Clin North Am **35**(1): 1-10.

[10] 119 Stat. 424.

[11] Section 923:

(a) The Secretary shall facilitate the creation of, and maintain, a network of patient safety databases that provides an interactive evidence-based management resource for providers, patient safety organizations, and other entities. The network of databases shall have the capacity to accept, aggregate across the network, and analyze nonidentifiable patient safety work product voluntarily reported by patient safety organizations, providers, or other entities. The Secretary shall assess the feasibility of providing for a single point of access to the network for qualified researchers for information aggregated across the network and, if feasible, provide for implementation.

(b) Data Standards.--The Secretary may determine common formats for the reporting to and among the network of patient safety databases maintained under subsection (a) of nonidentifiable patient safety work product, including necessary work product elements, common and consistent definitions, and a standardized computer interface for the processing of such work product. . . .

Beyond and loosely tied to all this there is a large and sophisticated discussion aimed at defining the metrics by which health outcomes can be precisely characterized and compared; there is a corresponding discussion regarding the design of data bases flexible, mutually compatible and secure enough to capture the information on patient conditions and treatments needed to determine how well our health care system is working, and why, precisely, it fails when it does.

But at the same time our current system if far from the one we need. The existing pieces can often not be connected because of institutional barriers or conflicts of interest. Crucially, our health care institutions have little experience of the kind of cooperative problem solving needed to make the system safer, more efficient and better able to take advantage of innovation. Training in medicine typically instills in doctor a hierarchical view of the provision of health care, with their profession at the top; the organization of large health-care providers apparently does little to change this professional formation. Thus a large scale study of an electronic voluntary error reporting system, encompassing 92,547 reports from 26 acute care hospitals, found that

> Of all reports, registered nurses reported 47%, pharmacists and pharmacy technicians 16%, laboratory technicians 10%, unit clerks/secretarial staff 10%, licensed practical nurses and nursing

---

(c) Information reported to and among the network of patient safety databases under subsection (a) shall be used to analyze national and regional statistics, including trends and patterns of health care errors. The information resulting from such analyses shall be made available to the public and included in the annual quality reports . . . .

> assistants 3%, and physicians (including house staff) 1.4%. The remainder of reports was entered by a variety of employees including medical assistants, physician assistants, physical therapists, security personnel, social workers, and risk and care managers.[12]

Seen from this perspective, we have a long way to go.

SEIU believes that the time is now ripe for national legislation that will help close the gap between our potential and our current practice by providing an institutional framework for encouraging hospitals to incorporate the organizational features and design principles necessary for quality, efficient, and innovative health care. The goal of this legislation is to create a process by which actors who are already engaged—or must be—in the construction of this safe, efficient and innovative system can coordinate and extend their efforts. SEIU is well aware that in so combining and extending their efforts all the actors in the health care system—unions no less than management, professional groups and oversight bodies—will have to learn new ways of ordering their own affairs and working with the others. As experience has shown that this adjustment will not be spontaneous, the federal government must nurture it, ever mindful of the considerable variation in conditions from hospital to hospital. The well-being of the country requires it.

[12] Catherine E.Milch, Deeb N. Salem, Stphen G. Pauker, Thomas G. lundquist, Sanjaya Kumar, & Jack Chen, *Voluntary Electronic Reporting of Medical Errors and Adverse Events,* J Gen Intern Med. 2006 Feb. **21**(2):165-70, at 167.

SEIU therefore proposes the National Healthcare Quality Act (NHQA). The Act assumes that, for reasons set out above, hospitals in the United States ought to be committed to the goal of providing safe and effective healthcare. The NHQA requires them to institutionalize the practices of organizational learning and continuous improvement that are prerequisite for the achievement of that goal. The purpose of the Act is to embed three foundation pieces in national healthcare policy:

I. Hospitals should create institutional structures dedicated to monitoring and evaluating the safety and effectiveness of hospital performance. These structures should be responsible for proposing and implementing changes in operating procedures that will improve hospital performance.

II. Labor law as applicable to the health-care sector must be reformed so as to reduce the current tendency for the rules of collective bargaining themselves to undermine workplace cooperation by exacerbating conflict and divisions between labor and management. But in correcting the defects of the current system, reform of labor law in the health-care sector must ensure that the employee and union participation in decision-making it encourages does not give unions veto power over the decisions of the QMBs..

III. The United States government ought to support hospitals in the task of designing and implementing institutional structures and practices of quality control. It must monitor the performance and help diagnose the sources of the failures of such structures; and it must through information and education spread the knowledge and know-how necessary to implement the structures and practices that best promote quality control.

I.

Hospitals should create institutional structures dedicated to monitoring and evaluating the safety and effectiveness of hospital performance. These structures should be responsible for proposing and implementing changes in operating procedures that will improve hospital performance.

The NHQA will require that any hospital that receives federal reimbursement for medical care must demonstrate its commitment to safety by establishing a Quality Management Board (QMB). The NHQA should require that every hospital receiving federal medical reimbursements must establish an QMB that is tasked (1) with monitoring errors and near-errors so as to learn their causes; (2) with creating a culture of safety in which errors and near-errors can be reported in an atmosphere of constructive engagement; (3) with designing and effectively implementing strategies and protocols for avoiding identifiable errors and near-errors; and (4) with monitoring the successes and failures of their own performance and designing improvements to as to increase their success-rate in detecting and remediating errors.

Some important features of the QMBs follow directly from the general principles underlying learning organizations introduced above. First, in every aspect of their operation QMBs will have to rely on the collaboration of the relevant actors across the boundaries of hierarchy and specialization. For front-line workers, at the bottom of the organization pyramid, this will require the elimination of barriers to participation and empowerment; we return to some of these below. At the middle and upper reaches of the organizational pyramid managers are unlikely to cooperate if they are punished—for example by

reduced pay or bonuses—for shortcomings revealed by the incident reporting system. For that reason there is a consensus, approaching unanimity, that the apparatus of error detection and correction should not be linked to incentive systems, at least for the foreseeable future; and the NHQA will, therefore, not attempt to establish such connection.

Note that it does not follow from this last restriction that the information produced by the QMBs will remain without consequence: The NHQA, following the example of regulation in the nuclear power generation and other industries, should require that the results of incident reporting and error correction systems be conveyed directly to the highest levels of hospital management and to the oversight bodies to which they are directly responsible. As serviceable metrics—for instance concerning distribution of reports by professional group and changes over time in reporting rates—become available, it should, moreover, be possible to compare the capacity of like hospitals to improve the quality of their performance broadly understood. Such comparisons could be eventually be used to establish, and periodically adjust standards for the certification of QMBs, and to inform the public of some aspects of hospital care.

Second, the general principles underlying learning organizations imply that the QMBs monitoring of its own operations should be diagnostic: designed to determine, and suggest remedies for the root cause of problems in the hospital's quality control systems, rather than simply register deviations from established

rules. The need for this diagnostic monitoring follows immediately from the recognition that most, if not all QMBs, in all their legitimate variety, are likely to have significant initial design flaws, and that learning from these—as from individual “incidents”—is indispensible to building a system that can reliably improve itself.

The NHQA will consequently require QMBs to perform regular, diagnostic reviews of their own operations, on lines analogous to, and thus easily integrated with periodic Federal reviews of QMBs to be discussed below. The assessments should be designed to detect and suggest correctives to shortcomings in workplace collaboration, flaws in the organization of management, and misalignment of the incentives and the goals of good care. Review of each category of care or level operation should draw on personnel of the relevant category or level. To assure that routines are subject to deliberate scrutiny, reviews should include outsiders as well as insiders to the institutions under review. Reviews should include and carefully distinguish between quantitative assessments of treatment outcomes (for instance: rates at which uncomplicated hypertension is successfully controlled) and qualitative assessments of service delivery (How well do specialists collaborate in the care of individual patients? How well is case information handed off between successive care givers?). This process should be integrated into the ordinary provision of health care.

Nonetheless, many crucial aspects of the organization of QMBs will have to be determined, perhaps in an explicitly provisional form, by collaboration among relevant parties in discussion leading to, or triggered by provisions of the NHQA. For example, should QMBs by certified directly by the Federal government? By the Joint Commission for the Accreditation of Healthcare Organizations? Either by the JCAHO *or* by those States already operating an incident reporting system? By all States, regardless of whether they presently operate an incident reporting system,*and* the JCAHO? By all the States alone? Or, to take another example, how should the QMBs mesh the development of the metrics they will use to capture features of hospital organization or processes that affect safety, efficiency and innovation with the metrics being developed by other entities to distinguish good and bad health care outcomes? To improve their capacity to adapt innovation, hospitals will need some means for routinely scanning for improved outcomes, and therefore some reliable guidance as to what counts as an improvement. And so on.

It may be that the NHQA will establish some general process or modality—call it a health-sector coordination conference—for convening discussion of such questions, responding to them, and periodically correcting the answers in the light of experience. For now it is enough to broach them, and to observe that is fully consistent with the processual goals of the act, and the self-correcting design of QMBs, to leave them unanswered at present.

So understood, the NHQA will rationalize and constructively shape present trends. The NHQA will simply insure that all hospitals participate in this trend in ways that are most likely to be effective.

II.

Labor law as applicable to the health-care sector must be reformed so as to reduce the current tendency for the rules of collective bargaining themselves to undermine workplace cooperation by exacerbating conflict and divisions between labor and management. But in correcting the defects of the current system, reform of labor law in the health-care sector must ensure that the employee and union participation in decision-making it encourages does not give unions veto power over the decisions of the QMBs.

The cooperation among hospital employees—*all* hospital employees—needed to improve quality, efficiency and the capacity for innovation cannot be achieved by legislative fiat. Legislation can help induce cooperation by setting goals whose attainment requires the actors to cooperate, and mandating the establishment of institutions pointing them in the direction of what is required. The NHQA does this by obligating hospitals to form QMBs. Beyond such inducements, legislation can encourage cooperation by removing legal and other obstructions to it. That is the aim of the labor law provisions of the NHQA.

Two circumstances frame the problem these provisions address. One is that the New Deal collective bargaining regime, crystallized in the Wagner Act and the regime it has generated, is so ill-suited to contemporary workplace relations that labor and management are more likely to invoke its provisions to

gain advantage in struggles between them, than to find a framework for composing differences.

Perhaps the most salient manifestation of this breakdown is the bitterness typically associated with the certification of new collective bargaining units: the unionization of a company or facility. The electoral process specified by the National Labor Relations Act is commonly subject to legal delays; it generates a great deal of stress and conflict; and it is costly to both union and employer organizations. It is often marked by vicious rhetoric by both sides and a variety of tactics designed to undermine the credibility of the parties, not the least of which are the filing of charges of unfair labor practices. The frequent result is a deep and lasting distrust among the parties, regardless of the official outcome of the election. All of this is antithetical to the atmosphere of co-operation and trust that an QMB must establish.

As a result, over the past 30 years, as it has become clearer that collaborative rather than adversarial relationships make economic sense,[13] unions and employers have skirted the Wagner Act and entered into neutrality agreements with increasing frequency. A “neutrality agreement” generally refers to a commitment by an employer to remain “neutral” during an organizing drive, rather actively to oppose the union. Neutrality agreements generally contain provisions in which the employer and union agree to refrain from making hostile

[13] *See* Adrienne Eaton and Jill Kriesky, *Union Organizing Under Neutrality and Card Check Agreements*, 55 Indus. & Lab. Rel. Rev. 42, 43 (2001).

statements about each other during organizing campaigns, and in which they set mutually agreeable ground rules for organizing campaigns providing for access and information sharing.[14] These agreements may also provide access to union organizers that would not otherwise be available. Additionally, neutrality agreements are also often accompanied by an agreement providing that the employer will recognize the union as the collective bargaining representative upon a majority showing of support through a "card check" or through a non-NLRB election.[15]

But the very success of non-NLRB elections has invited challenges to them by partisans of the Wagner Act regime. To take only one example: Prior agreement between labor and management on the contents of the collective bargaining agreement that will be in place *if* employees establish a union by card check arguably infringes the right of employees, as members of an already established union, to vote on contracts agreed by leaders of their explicit choice.

Unless limited by legislative waivers, skirmishes over this and other seeming technicalities could easily make neutrality agreements in the health-care sector as acrimonious as the NLRB elections they are designed to avoid. This

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

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

sectoral qualification is important. We know unionization is not always a precondition to effective cooperation: Think of the bio-technology and semi-conductor industries. But in sectors where large numbers of employees have, or are likely to exercise their right to organize unions, it is imperative to (re-) establish an organizing process that is not self defeating for all parties.

A second manifestation of the poor fit between the NLRB regime and the requirements of contemporary workplace cooperation is the sharp line labor law draws between managers, who are excluded from bargaining units, and non-managerial employees, who alone may constitute it. Behind this distinction lies a fear, especially pronounced in the decades before the passage of the Wagner Act, that firms will create sham, “company” unions, dominated by management but just sufficiently representative of the workforce to obstruct organization of a truly independent bargaining unit. For reasons we will come to in a moment there is still legitimate currency to some of these fears. But the NLRB solution of excluding managers from bargaining units is simply unworkable today. The de facto decentralization of “managerial” decision-making authority towards front-line workers effaces the line between managers and non-managerial personal in few sectors more dramaticalluy than in health care. The QMB is premised on, and accelerates the effacement of this distinction; its success must not be hostage to the to and fro of disputes rooted in the labor law of a bygone age.

But the limitations of the NLRB regime constitute only half of the problem that the labor-law provisions of the NHQA must address. The other half is the role of the union—no longer deformed by a bitter certification process and artificial distinctions between types of problem-solving employees—in the operation of the QMB and related institutions, such as the Federal monitoring system described next. Here the issue is not the legacy of an outmoded system, but rather the absence of robust alternative models.

More precisely, we lack, both in the United States and in other countries with rich histories of collective bargaining, well established examples of unions able both to engage in the familiar negotiations between labor and management over terms and conditions of work, *and* to participate fully and formally in the operation of continuous improvement institutions of the sort that prefigure and inform the QMB. Informal accommodations abound: Otherwise it would be hard to understand how quality improving institutions have so often diffused in firms and sectors with long histories of engagement with unions traditionally focused on “job control” and the detailed bargaining over task definitions that implies. There are, moreover, within the ambit of the SEIU and elsewhere, new programs of collaboration between labor and management that could, sooner rather than later, cohere into an alternative model combining in workable fashion key

elements of collective bargaining and the co-management of quality improvement and the continuing re-organization associated with it.[16]

But informal accommodations operate, by definition, behind the façade of continuing affirmation of standard forms; they suggest how to work around traditional understandings without providing models of renewal. By the same token promising programs are just that: experiences we need to follow closely to gain further clues to the solutions of problems still beyond our reach.

The upshot is that in protecting the QMBs against the conflictual and divisive legacy of the Wagner Act regime, the NHQA must not assume that removal of this obstacle, by itself, will ensure that labor and management find their way to the necessary forms of workplace cooperation. On the contrary, in the absence of reliable alternatives to conventional collective bargaining regimes, we must contemplate, and the NHQA must afford protection against, the possibility that the legislation, in facilitating non-NLRB organizing, opens the way

[16] An possible example of such a promising program in the healthcare area, one consistent with NHQA principles, was initiated by Local 1199 of the Service Employees International Union (SEIU), and their multi-employer association, the New York League of Voluntary Hospitals and Nursing Homes. These institutions created a formal partnership in 1997, funded by the League contract and called the Labor-Management Project. The Project formally covered over 125,000 members of 1199/SEIU working in dozens of non-profit hospitals and nursing homes that are members of the League. The Labor-Management Project sits within a broad, strategic alliance, a cooperative relationship aimed at improving patient care, assisting workers retain their employment if hospitals close, and protecting and increasing public funding for the healthcare system. It has sought to expand opportunities for worker participation in improving the quality and safety of patient care, the quality of jobs, and patient satisfaction scores. A recent report summarizing the results of the Labor-Management Project cites a variety of results including increased patient and employee satisfaction, reduced grievance rates, and cost savings from specific project initiatives. Report of the International Action Research Project (no date).

for unions to assert control over QMBs, and thus over key aspects of the organization of hospitals. This could occur, for instance, if the NHQA strongly penalized employers for violating neutrality obligations—say by forfeiting Federal reimbursements otherwise due—and a union could, under the law, claim an employer was violating the obligation by opposing language in a prospective collective bargaining agreement requiring union asset to all QMB decisions.

The NHQA will thus have to address both the obstructive legacy of current labor law, and guard against abuse of the facilitations it creates to do this. On the one side, it must be explicit that, notwithstanding past statutory provisions, employer neutrality is required as a precondition for federal reimbursements to hospitals on the ground that employer neutrality is necessary to promote safety in American healthcare. See Box 1/Appendix A for detailed proposals. But the NHQA should also provide that no collective bargaining agreement can modify, override, or constrict the recommendations and proposals of a recognized SMB. The NHQA requires employer neutrality so as to supplement and sustain the operation of QMBs and to increase the likelihood that employees can actively and fully participate in QMB sponsored processes of quality control. Unions today can be an important if not essential component of this process. But unions ought not to be permitted to limit or constrain the actions of QMBs.

The SEIU is well aware of the tensions this two-sided reform of labor law in the health-care sector will provoke. We are especially mindful of the possibility

that QMBs with substantial powers to shape work-place organization, and shielded by law from direct union influence could, if misused, become a new version of the works councils that often masked company unionism nearly a century ago. When we said at the outset that effective cooperation in the health-care sector would require the actors to learn new ways of ordering their own affairs and working with the others we had this risk in mind, among many others. We will see next that the most promising method of Federal review of QMBs may have the collateral advantage of reducing this risk. But one way or another we are determined to face and resolve these challenges. As we know, pretending they do not exist, or—what is the same thing—that we already have solid answers to them, is to invite catastrophe, perhaps in the form of desperate but ill-considered public intervention down the road.

III.

The United States government ought to support hospitals in the task of designing and implementing institutional structures and practices of quality control. A key element of this support is diagnostic review, by the Federal government of the performance of QMBs.

The NHQA contemplates that each hospital establish the QMB appropriate to its circumstances. It is plain that in present circumstances the development of quality improvement mechanisms should leave ample room for local experimentation and development, consistent only with the structuring elements and general principles set out above.

Even in a deliberately decentralized system emphasizing the role of local autonomy there is nevertheless a crucial place for the national government. Some aspects of the requisite national presence are straightforward: The Federal government should certify whether hospitals have institutionalized an adeuate QMB. Unless a hospital possesses a certified QMB, it will not qualify for federal healthcare reimbursements. Relatedly, the Federal government should work with hospitals to provide technical assistance, including identification and sharing of best practices, in the design and operationalization of QMBs.

But it is unlikely that the Federal government will be able to achieve these apparently limited ends unless it engages in a third and more demanding task: the diagnostic review or monitoring of the operation of QMBs. Such review would be patterned on the quality service reviews (QSRs) increasingly common in child welfare and other human services in the US. These QSRs amount to collaborative, diagnostic quality control of local quality control systems: qualified teams of insiders and outsiders (from other units of the organization under scrutiny, or from like organizations operating in other domains) periodically review representative, individual cases of decision making to indentify errors, their root causes, and possible remedies. They allow organizations as wholes to learn from their best performing parts while increasing the capacity of the whole organization to learn.

Accordingly the NHQA should require that an agency in the Department of Health and Human Services—the present Agency for Healthcare Research and Quality (AHRQ) or a new entity—should be tasked with regularly reviewing the operation of individual incident reporting systems and—by means of QSR-type review of particular cases or problems—the capacity of QMBs to respond effectively to the shortcomings they reveal.

Federal, diagnostic review of QMBs (like the reviews undertaken by the QMBs themselves) have four functions. The first is as a forum for clinical training for doctors, nurses, other hospital employees, and their supervisors. The experience of presenting in its particularity an actual case, and receiving critical feedback on it from peers and mentors is the core form of professional development in much of health care. The Federal (and local) QSRs extend that tradition by showing how continuing peer review is compatible with such review. Put another way, ongoing peer review illustrates that expertise and specialization is not synonymous with hierarchical authority.

Second, this review process is a form of norm elaboration that engages all levels of the system, as well as outside experts. The meaning of adequacy with regard to goals like hospital safety, efficiency and the capacity to respond to innovation is, in the abstract, indeterminate. The QSR is a collaborative process for specifying what counts as “adequate” in these and other domains through analysis of cases. We know from experience in analogous

domains that scoring systems can be devised to induce reviewers to formulate their judgments in forms sufficiently precise to permit comparisons across cases. The various discussions among reviewers aimed at "inter-rater reliability" and the exchanges between reviewers and frontline workers promote convergent understandings of how the standards apply in particular cases. Federal reviews of QMBs can thus eventually help establish credible baselines for evaluating performance and acceptable rates of improvement.

Third, Federal review of QMBs will give rough but serviceable indications of system-wide problems, and thus of where attention and remedial effort may need to be focused early and broadly.

Fourth, the QSR facilitates legislative and professional oversight by making program performance more transparent. Legislative oversight is often thought to be limited to “police patrol” procedures that audit for compliance with fixed rules and “fire alarm” procedures that respond to reports of discrete abuses. The experience with the QSR in child welfare suggests that including legislators in these reviews creates an alternative that could provide far richer information. Participation in Federal review of QMBs by doctors, nurses, other hospital specialists, as well as by representatives of their professional or employee organizations could set the stage for analogous innovations in oversight. Indeed it could well be that participation by unions and professional groups in these Federal reviews could allow them to influence and contribute to quality reform

without entrenching parochial interests—and thereby help relax some of the tensions created by the Janus-faced reform of labor law the Act proposes. The NHQA should therefore authorize such participation.

Thus in its methods of Federal review, no less than in its approach to improving safety, efficiency and the capacity for innovation in individual hospitals the NHQA seeks to balance centralization and decentralization, local iniative and system-wide learning, and respect for the experience of each and every hospital, and a national commitment to ever better and more broadly accessible health care.