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Cover Page Footnote

This article is based on interviews with hospital workers, management, and WEP program staff. The analysis draws on limited class observation, discussions at WEP Advisory Board meetings, and survey responses from 231 WEP participants. In addition, I reviewed WEP program records and reports. For detailed survey results, see the final report of the WEP Evaluation Project, Andres Torres, The Worker Education Program: A Summative Evaluation (Boston: University of Massachusetts, Center for Labor Research, 1994). I thank Michael Bishop, Francoise Carre, Maria Estela Carrion, and Christine Hayes-Sokolove for their able assistance in the evaluation project and James Green for his comments.

Workplace Education at the Bottom Rungs

Andrés Torres, Ph.D.

In the late 1980s, observers of the Massachusetts hospital industry were predicting a severe shortfall in skilled technical workers. The Worker Education Program (WEP) emerged as one of several responses to this projected labor shortage. It was premised on the idea of an internal solution to the need for workforce development, shifting the focus from external recruitment to upgrading of incumbents — nutrition, maintenance, clerical, and secretarial staff — and from traditional classroom training to workplace education. Other features of the WEP model made it an extremely interesting experiment: it was operated by labor-management partnership, it was located statewide in nine different hospitals, it offered a college prep as well as a college-level curriculum, and it involved community colleges in a collaborative network. The author provides a narrative and assess-ment of the WEP, reporting the results of surveys and program observation. Participants, who were overwhelmingly positive in their evaluation of the program, provide insights into the ambitions and fears, needs and hopes, of lower-tier workers in the industry. The reasons for the failure to institutionalize the WEP — economic and institutional — are also discussed.

An Alternative Education and Training Approach

They filed into the auditorium one by one and took their seats. The often overlooked employees of the hospital's service and administrative departments — the clerical, nutrition, and dietary staff, the maintenance crew, and others — had come to hear about a new program that sounded too good to be true. They were offered a chance to attend hospital classes — during workdays, for which they would receive paid release time and subsidized tuition — in an education program to improve their skills, potentially leading to a job promotion. Management and the union had set up a program that would enable employees to earn college credit and advance themselves professionally.

Just before the session got under way, the curious audience was again surprised by a request of representatives of the Worker Education Program (WEP) that, rather than conform to the traditional grid of rows facing a speaker, the women and men rearrange

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their chairs into a large semicircle. The message seemed to be that employees should have an unobstructed view of the proceedings and feel they were equal participants in a cooperative enterprise. The symbolism was not lost on the audience, and indeed, this project promised to be something new.

Two years earlier, in 1988, the commonwealth of Massachusetts had ratified the Labor Shortage Initiative, a measure designed to expand the supply of workers in the industry. Health care services had become a beneficiary of economic expansion during the "Massachusetts miracle" of the 1980s, but industry observers warned that future growth was contingent on finding new cohorts of skilled labor.[1]

Under Section 83 of Chapter 23 of the Acts of 1988, the state Department of Medical Security was authorized to develop and fund programs to meet this need. Prospective trainers would have to demonstrate previous industry experience and be permitted to offer any of the following program models — direct training of health care workers, career ladder development for professionals, as well as child care opportunities and support services. Funds would be generated by a levy on acute-care hospitals of one-tenth of one percent of their gross patient services revenues.

Perceiving an opportunity to pilot an experiment in upgrading worker skills, a number of interested people formed a planning group to discuss developing a proposal focused on a work-site-based career ladder program. The group included Service Employees International Union (SEIU) Locals 285 and 767 and representatives of the Service Employees International and of the University of Massachusetts Boston, Bunker Hill Community College, and Boston's Economic Development and Investment Corporation.

The unions, particularly Local 285, were the prime movers in bringing the project to fruition. The Worker Education Program was viewed as a vehicle for attaining an important strategic goal, namely, creation of a state-sanctioned education trust fund to finance training services for hospital workers. In the early 1980s, Local 767 had suggested the same type of scheme in collaboration with a number of southeastern Massachusetts hospitals.[2] Similar programs had been established in New York and Connecticut, largely through the efforts of Health Care Workers Union Local 1199.

The initial WEP idea, submitted in the summer of 1990, was one of a number of successful proposals in an intensely competitive field. Approval for a one-year, renewable grant was secured in the fall, and the WEP began operations at the start of 1991. Funds were allocated for the program leaders to hire a small staff and set up an administrative center at SEIU Local 285 headquarters in Boston.

The contract specified that the program be established in nine hospitals throughout the commonwealth, all acute-care facilities with labor shortages, in which the SEIU was organized. The participating hospitals selected were Boston City, Burbank in Fitchburg, Cape Cod in Hyannis, Falmouth, Framingham Union, Hale in Haverhill, Hillcrest in Pittsfield, Jordan in Plymouth, and North Adams Regional.

The general model mandated a comprehensive program of career training directed at what were called Tier 1 and Tier 2 employees, workers on the bottom rungs of the career ladder in the hospital labor force. Tier I primarily includes blue-collar and manual-labor personnel involved in maintenance, patient transport, and dietary and related functions, while Tier 2 is composed of office workers, ordinarily clerks and secretaries. Members of these two groups, who typically have no college degree, face few prospects for upward mobility unless they can acquire training in a college-level curriculum.

Beyond these entry-level tiers, the hospital labor force includes employees in profes-

sional categories, for example, allied health professions, nursing, management, and medical specialists. The allied health category, often envisioned as the next logical step in the mobility path of hospital workers, encompasses various types of technical positions such as medical radiography technologist, respiratory therapy assistant, physical therapy assistant, radiation therapy assistant, and others. The WEP seeks to train current Tier 1 and Tier 2 workers for these occupations. Hospitals have traditionally filled these positions through direct recruitment from higher education institutions devoted to preparing health care professionals. The minimum requirement for such jobs is an associate degree in a relevant field.

Philosophy

The WEP, designed to test the viability of work-based training models to address hospital needs for skilled health care workers, is premised on an internal solution. By targeting hospitals' Tier 1 and Tier 2 employees and providing structured, job-related training opportunities, WEP models offer a new route to meeting changing conditions in the allied health professions. Rather than recruiting solely from traditional health career training programs, hospitals are encouraged to fill Tier 3 jobs by identifying experienced and motivated employees from within.

The initial plan identified three points of consensus among the parties, themes that ultimately provided the rationale for the project. There was agreement that (1) hospital performance is plagued by a persistent shortage of skilled personnel; (2) existing employee staff within hospitals provide a pool of potential workers to meet this shortage; (3) improving general education levels among hospital workers and providing access to college education requires a long-term commitment of the hospitals, unions, and higher education institutions.

Programmatic and Policy Goals

The four broad goals of the Work Education Program were (1) collaboration, (2) training and formal education, (3) career advancement and job restructuring, and (4) systemic change. As the project evolved, some of these goals were revised.

Collaboration: WEP's collaborative goal touched on several areas, its basic theme being to foster working relationships among critical partners who would be responsible for joint delivery of education and training services by the following actions.

To oversee WEP operations, create a labor-management advisory board comprised of representatives from hospitals, union locals, higher education, government, and the allied health professions. The longer-term purpose of the board was to secure independent financing.

Establish hospital-based labor-management committees at each site to monitor the design and implementation of each program. These committees were to identify labor and training needs, implement courses and programs, assist with outreach and recruitment, and develop and negotiate new programs.

Initiate a collaborative of health care practitioners, worker-students, and academic experts to advise on curriculum design and delivery.

Training and Formal Education: WEP proposed to develop a replicable model of comprehensive training and formal education to be delivered at hospital sites and participat-

ing community colleges. It was stipulated that courses would satisfy appropriate standards for certification, licensure, and academic credits. The final objective for an individual worker was career advancement to an allied health profession. Initially, designated occupations were radiologic technologist, nuclear medicine technologist, radiation therapy technologist, and physical therapy assistant. Six distinct processes were envisioned as comprising training: outreach, assessment, precollege education, college-level curriculum, internship, and mentorship.

Career Advancement and Job Restructuring: The originators of the pilot articulated additional goals related to hospital employment structures and mobility. WEP was perceived as a model for promoting career advancement and job restructuring for hospital workers languishing in the lower occupational categories, while opening new jobs to underrepresented populations. As the existing workforce moved up the ladder, minority workers would be recruited to fill vacancies in entry-level categories. Institutionalization of career ladder/lattice programs would help establish a mechanism for occupational mobility and increasing diversity in the labor force.

Systemic Change: Finally, WEP proposed to facilitate systemic change in the health care industry, pursuing objectives that would enhance the quality of the labor supply and improve working conditions. Suggested steps included the following.

- Develop programs to increase understanding and acceptance of the special needs of allied health care workers for workplace-based college education programs.
- Promote job evaluation and restructuring that results in increased wages and greater career mobility.
- Consult with community colleges providing allied health care programs to develop understanding of the special concerns of adult learners among the working poor and to ensure full articulation agreements among community colleges.

As can be ascertained from the preceding, WEP's original formulators were not timid in their expectations for the project. In addition to proposing a substantial service delivery component, containing three distinct program tracks — adult basic education, college courses, and internships — WEP took on the task of promoting structural changes in a highly complex and uncertain industrial climate.

In an effort to achieve these formidable goals, program leaders were to find themselves continually confronted with difficult choices. The challenge of selecting among competing demands on resources, of reexamining priorities and modifying program in midstream, became mainstays of the Work Education Program experience in the following three years. It is no exaggeration to say that WEP's proposed mission bordered on the audacious. By the same token, its vision and scope made it an intriguing and exciting experiment in workforce development.

The next two sections summarize the main phases in WEP's activities, focusing on the precollege- and college-level courses.[3] Note that this article does not address the special track dealing with a group of interns being prepared for promotion to jobs as medical radiography technicians.[4] WEP ran two cycles of classes each year from 1991 through

1993, with a total of 824 enrollments.[5] This brief account, which focuses on milestones and turning points, cannot do justice to all the intricacies and drama of an experimental program that set out to break new ground in the field of workforce development. Nevertheless it helps to set the context for assessing the WEP model.

Implementing Workplace Education: Year One

The original plan called for the first cycle of classes to begin in the spring of 1991, but as often occurs with new programs, start-up was postponed. Several factors led to an unsteady implementation phase.

For most hospitals and the lead union local, workplace education was a new experience. Few employers had a track record in delivering educational services to Tier 1 and 2 workers, much less in sponsoring apprenticeships to upgrade workers to technical positions. One important exception was the Career Ladders Program sponsored by Local 767 and its hospitals, but these sites did not start operations until Cycle 2. Local 285 had never taken on a program as ambitious as WEP. A change in the union's leadership in the final months of 1990 complicated matters. A newly elected president assumed responsibility for the program, but she had not been involved in the conceptualization or development of the WEP proposal. Indeed, it was the outgoing officer who had negotiated the original contract for Cycles 1 and 2, specifying the starting date for the first cycle.

Additional time and energy was expended in basic start-up activities: hiring WEP staff — a full-time project director, a part-time counselor, and a part-time administrative assistant; establishing a central office; and working out curricular and teaching arrangements with the community college serving as educational provider. Within a few months it was necessary to search for a replacement for the original director, who had been hired on a short-term basis to inaugurate WEP's activities but was not available to administer the program beyond the first six months. The first major modification was to delay the start of Cycle 1 to the summer of 1991. The permanent program director came on board in June, just prior to the launching of classes.

Site Dispersion

Several reasons contributed to these faltering beginnings, but perhaps none was as important as the overly ambitious scope of promised activities dating from the 1989–1990 proposal-development phase. The goal of establishing the program at nine different hospital sites was especially demanding. No other project funded by the Department of Medical Security came even close to serving such a range of sites.

This predicament stressed resources by forcing staff to reproduce start-up activities in many organizational contexts. In January through March 1991, the first project director spent most of the time on the road working out final agreements with individual hospitals. Several issues had to be spelled out in terms relevant to each site: specific arrangements for clinical training, that is, assuring the logistical and mentoring aspects of the apprenticeship piece; release-time agreements; on-site academic training; achieving an accord on upgrading participants during and after training.

Program staff had to contend with a wide range of hospital settings in the nine locations: urban, suburban, and rural; community-based and teaching; private and public. Taking the differences in course offerings and sites into account, there were nine distinct program activities during Cycles 1 and 2. The demands thus placed on program

and hospital staff and the educational provider were enormous.

Determining curriculum was not as easy as one might expect, as illustrated by the words of the second program director.

> When we began offering courses in the workplace no one really knew what to offer first. Although assessments were done in some locations, they were more focused on academics than on assessing workplace skill level. In addition, no one knew the educational needs or desires of the workforce. The workers themselves were initially wary of the program. They were concerned about confidentiality — whether their supervisors and peers would find out what they did and didn't know.[6]

Beyond this was the complexity of WEP's program design. With three tracks, each serving different types of workers, it was unreasonable to assume that all hospitals would support each type of activity. Following the course of the peculiarities of each site's operations was no easy matter. Needless to say, concentration in fewer, more closely situated sites would have made the start-up phase more manageable.

Ironically, the Service Employees International Union's willingness to operate a training model in so many hospitals made its proposal quite appealing to the Department of Medical Security (DMS). WEP was the only statewide model, all other DMS-funded projects having been approved for individual facilities mostly in the greater Boston area. WEP allowed DMS to show the Massachusetts elected officials that it was servicing a broad spectrum of the health care sector.

From SEIU's point of view, a broadly dispersed program fulfilled certain goals. It placed the union in the position of taking on a risky, yet potentially rewarding project at a time when it was looking for ways to stimulate membership involvement in the life of the organization. WEP also offered a chance to reach locals in the western part of the state, where workers rarely have access to innovative opportunities for career advancement.

Finally, during the early period of proposal development, it was hoped that the "distance-learning" model could be linked to fiber-optic technology. WEP would then have been positioned on the ground floor of a major breakthrough in work-based education. However, this idea has yet to bear fruit in the commonwealth, as the telecommunications industry must still establish the commercial feasibility of this technology.

If program staff saw this dispersion as problematic for WEP's implementation phase, union leadership seemed willing to face the consequences, given the political importance of piloting a statewide model. Other issues affected program implementation, some that could be traced to initial conceptualization and some that surfaced in the first year, especially during Cycle 1.

Unrealistic Goals

Unrealistic goals had been set with regard to the outreach-assessment-placement process for the first two cycles. The original proposal to the Department of Medical Services of June 28, 1990, had promised that, for Cycles 1 and 2 combined, WEP would conduct assessments on 300 student-workers and enroll 500 workers in the full range of educational programs. These figures turned out to be much too ambitious. By the first cycle, 64 had been assessed and 48 enrolled. By the end of Cycle 2, a total of 108 had been enrolled.

The first project director said that WEP faced the dilemma of a well-meaning but

"grandiose concept." Everyone underestimated the required start-up time. The union could have used more lead time to set up office facilities; as it turned out, the project director found herself having to do this alone. At one point there was uncertainty even over the future existence of DMS, with rumors circulating in political arenas that the agency was targeted for elimination. This raised doubts about whether funds would continue flowing to WEP.

Another problem surfaced in connection with the plan to set up an internship component for physical therapist assistant (PTA). Initially, WEP proposed to cover two technical areas, PTA and medical radiography technician. But preliminary canvassing of educational providers indicated that community colleges were less than enthusiastic about innovative curriculum delivery to hospital work sites. Most colleges already had sizable waiting lists for their regular programs in this field, and WEP staff sensed that these institutions were reluctant to enter into new relationships that would require special articulation agreements.

By summer 1991, labor-management committees were being encouraged to recruit for the medical radiography, as opposed to PTA, internship slots. At least in the medical radiography area, the program could count on a solid relationship with Bunker Hill Community College, which had firmly committed to the project. Later, in 1992, it was decided to drop the idea of a PTA internship and focus on the medical radiography internship.

Fortunately, the DMS was extremely helpful in adjusting the program's scope and amending the original goals and expectations. Program staff worked closely with the state agency during the first year, covering Cycles 1 and 2, to modify target goals. Once it became clear that the original numbers were unrealistic, they were adjusted to take into account the complexity and scope of the program design.

Staffing

Relying on one full-time project director and the two part-time assistants, one counselor, one clerical, the core WEP staff was grossly understaffed for the task at hand. Even the educational provider (see below) was able to hire only fractional time of certain administrative and academic personnel to supervise delivery of educational services from pre-college courses to the internship component. Limited funding for personnel was a stark example of the gap between goals and available resources.

Community College

As with the labor-management partners to the project, WEP was an experimental effort for Bunker Hill Community College, the prime educational provider, which had not participated in a program quite like this. The college has expertise in training students for the allied health professions, but regular classes are held on campus. Clinical training is often arranged with cooperating hospitals, but students are not employees of the sponsoring hospital, as in the case of WEP. It took awhile for college staff to become familiar with the WEP model and define its functions and responsibilities.[7]

In addition to responsibilities related to the medical radiography component of WEP — with attendant concerns about delivering a clinical program that would meet accreditation standards — the community college had to identify appropriate teaching staff for the precollege- and college-level courses to be given at hospitals. In the first year, time limitations were such that faculty were not given the opportunity to develop and prepare curriculum, especially for Cycle 1.

Assessment

There was disagreement over the student assessment policy, with WEP staff and union officials questioning the appropriateness of computerized testing procedures and instruments used by the educational provider. For Cycle 1, consisting of developmental courses in English as a second language/Adult Basic Education and introductory college courses, testing was conducted for all applicants. But program staff felt that students were intimidated by the examination process, and subsequent cycles basically dispensed with these tests.[8] Unfortunately, in Cycle 2, consisting entirely of medical terminology courses, a number of students found the course work too demanding and dropped out, suggesting that assessments might have been useful in identifying unprepared learners.

Adjustments

Given the extremely ambitious scope of the original plan and the many constraints with which the program had to contend in the first year, the program delivery experience was quite remarkable. With Cycle 2, operations became greatly stabilized as the various institutional partners learned from the experience of Cycle 1, improved coordination, and made key adjustments, of which there were several. The most significant modification was the scaling back of participant numbers and program complexity. The original goal for classroom participants was determined to be wholly unrealistic and reduced to about a third of the original target (almost 500 for year one).

An important transition occurred between Cycles 1 and 2. The shift from a curriculum of precollege- to college-level courses, all in medical terminology, in effect represented a shift in focus from Tier 1 to Tier 2 workers, who are better prepared academically and primarily employed in suburban hospitals. Some observers and participants in program operations worried that WEP might abandon the original commitment to Tier I workers, who have a special need for college preparatory courses. In year two, the ratio of college to precollege courses became more skewed, with nine courses in the former and three in the latter. It appeared that in the tug of war over how to deliver curriculum, the needs of Tier 1 workers were being neglected, which seemed to be the price paid for the Work Education Program need to retrench on its original goals.[9]

Despite the somewhat chaotic atmosphere of the opening year, WEP was successful in mounting the first statewide program of work-based training programs. Recognition of this accomplishment came when the program received renewed DMS funding for the second year. WEP's proposal was among the highest rated of all submissions to the second-round competition for the Labor Shortage Initiative.

Consolidation and Expansion: Years Two and Three

By early 1992, program staff and advisory board members were expressing a highly positive, upbeat view of the Work Education Program's development. Cycle 2 had been a big improvement over Cycle 1, and Cycle 3 was proceeding well. Considering that an entire year's educational programming had been compressed into a six-month period, there was reason to be relieved that the birth pains were over.

There was greater competition for entry into courses, suggesting that the more ambitious and better prepared workers would enroll. WEP found it difficult to meet the demand for classes as the majority of participating hospitals expressed the desire to offer at least

one course each cycle.

In mid-1992 Cecilia Wcislo, the union president, offered an assessment of WEP progress. Despite occasional problems with individual supervisors on release-time issues, the recent Cycle 3 graduations demonstrated a high level of employee identification with and support for WEP. Employees, learning that they could meet a challenge, and feeling smart, displayed increased feelings of self-esteem.

According to Wcislo, WEP was encouraging people to realize that it is never too late to learn and advance themselves. Some supervisors and managers were surprised that workers were so positive about this experience, perhaps harboring envy of the enthusiasm of many workers. Within the union, there had been a lot of positive feedback on WEP's progress. At their convention, stewards and members voiced great support for WEP. The exceptional competence of its project director, who had been key to the success of the previous year, was a critical factor in the program's improvement.

A further sign of the overall positive assessment of WEP was provided by the Department of Medical Security when, in the summer of 1992, it awarded WEP a third grant for $425,000. These funds would allow the program to service some 250 students in Cycles 5 and 6 and to continue support for the eleven medical radiography interns.

Release Time and Other Coordination Issues

By mid-1993 there was a marked improvement in the refining and handling of release-time policy at the various sites. The following fundamental issues were discussed by the WEP Advisory Board during 1992. Tensions may arise between front-line supervisors and their superiors if the hospital fails to inculcate a long-term view among the former. In the case of English as a second language courses' affecting specific departments, some unit heads become concerned because backlogging work is burdensome. For example, in transportation departments, employee schedules are driven by the need to service patients on an on-call basis, a situation further aggravated by the hospitals' pattern of eliminating positions first in Tier 1 jobs like housekeeping and dietary units, most of which were especially lean in the existing economic climate. These problems, especially scheduling, are not as severe in clerical units, where staff have greater flexibility in scheduling their workload. It is relatively easier to backlog, speed up, or share tasks with coworkers, thereby fitting class sessions into the daily routine. Generally, supervisors want quick payback for the adjustments they are asked to make. A six-week computer course targeted at receptionists and typists quickly gains support because results are readily seen.

There was also tension among workers. Competition, resentment, increasing workloads on nonparticipants, came into play. All unit employees, not just the students, need to be made aware of the changes implied by WEP participation. How can these issues be dealt with? The more directly a hospital can involve supervisors, perhaps as mentors, the more support it gains for the program. This implies a philosophy and work environment aimed at bonding rather than separating workers and management.

Suggestions for improving coordination included written agreements between the union and hospital laying out the terms of WEP participation; invitations to supervisors and management to attend graduation ceremonies; making the program more visible within the hospital and the community.

It also helps to make unit directors responsible for collecting sign-up sheets so that they know who is applying. Supervisors resent being informed at the last minute that a member of their department is enrolled in a program. Somehow the hospital and WEP

have to reassure supervisors that they will not lose valued employees to another unit or that their budget lines will not be eliminated when WEP students are promoted. Finally, unit supervisors have to know that a high-level administrative officer such as the vice president of human resources endorses the entire effort.

Negotiating the Future: Uncertain Prospects

In the fall of 1992, during collective bargaining negotiations with two participating hospitals, there emerged early signs of hospital resistance to the creation of a permanent trust fund that would guarantee long-term survival of WEP. The lead union sought to include this item in the new contract but was rebuffed by employers. An important underlying factor contributing to this resistance was the perception of WEP as a union-driven project. Some management personnel believed that WEP was not really a joint project. Despite a great deal of effort expended by their organizations, they felt that the union received top billing, reflected, for example, in the WEP letterhead, which did not list the names of participating hospitals.

The union rejoinders — that it contributes many of its own resources like overhead and staff time, that graduation ceremonies are held on site and amply recognize employer contributions, that employees regularly express gratitude to their employers for allowing them to participate in WEP — all failed to dampen the criticism. It was becoming evident that the management side did not view WEP as a long-term effort.

In the third year of operations, with expanded support from DMS and two years of experience under its belt, WEP's course offerings and the number of students enrolled surpassed the combined levels of the previous two years.[10] The year was characterized by a much smoother and steadier pace of activity even with the greater scale of programming. By late 1992, planning had already begun for Cycle 5 classes, and labor-management committees had refined the complex process of outreach, recruitment, and selection.

Assessment

With the entry of new community college partners in western Massachusetts and Cape Cod, the issue of assessment policy was resurrected. Both educational providers expected Work Education Program applicants to follow normal procedures adopted by the institutions for entering students. Some workers were not given release time for testing; others were intimidated by the process, a problem WEP had worked hard to avoid in the previous cycles. A three-hour written test at one school led to friction between the educational provider and WEP representatives. Since courses for Cycle 6 were not offered at these sites, the issue was not revisited. Applicants at the second school expressed discomfort and anxiety over having to take a computerized test, saying it was an uncomfortable experience and affected their performance.

Introduction to Health Careers Seminar

An intensive noncredit course of five three-hour sessions was devised to offer career orientation and assessment to hospital workers. Designed to counsel workers in creating individual education plans and to invite a series of guest speakers from various hospital departments, it was successfully piloted at a WEP site during the summer. The workers were given a comprehensive tour of the hospital to familiarize them with its various departments and functions. The project included a special component dealing with

adult-learner study skills. WEP staff developed a training program in basic learning methodologies for adult workers intended to aid them in retaining course content in conjunction with other orientation activities. Topics included myths and realities about older students, note taking, and reading techniques.

WEP Contributions to Hospital Employees

Responses to worker surveys provide additional information on WEP's effectiveness and impact. Employees reported a high degree of satisfaction with the program, variously expressed to evaluators in telephone interviews.[11]

An overwhelming number of learners, more than 90 percent, felt that the Worker Education Program should continue. Given the opportunity, the great majority would have liked to go on in the program. Most participants expressed the view that their WEP courses helped their job performance and improved their grasp of basic skills in reading, math, and English.

Employees proposed no fundamental changes in the program design beyond that of expanding course offerings and providing greater access to those who were unable to gain admittance during the first two years. A number of suggestions for improving WEP were gathered.

> Offer it to more people; have several classes going on at the same time so more can participate.
>
> I really enjoyed the program; I can't imagine what would improve it, possibly the time of day, if it could be in the morning. I found it difficult to leave what I was doing at three P.M.
>
> More courses should be offered; if two people want to take a course they have to draw straws. Offer more courses so that those without seniority would be able to get into a course. Make the program more available, have more slots.
>
> It is the best educational program I've seen in the health care system. Lab tech, med tech courses, and business courses would interest me.

The most common response was simply "Nothing" or "Nothing I can think of."

Worker-students gave highly positive ratings regarding the classroom experience. They felt comfortable about asking questions in class and were capable of keeping up with assignments. They were enthusiastic in their opinions of their teachers and enjoyed having coworkers as classmates. The course material covered topics relevant to their current functions or potential job positions. These themes were affirmed when workers were asked what they most liked about WEP.

> My classmates were very friendly and it made it easier to study together.
>
> They try to help me; for me it was the opportunity to develop English skills.
>
> We had an excellent teacher; she had a way of relating things to everyday life so you could remember them.
>
> It was enjoyable; the teacher made you feel good about yourself.

Enabled me to feel like I can accomplish something.

The satisfaction of getting an A.

It taught me a lot of things I use on my job.

Helped me do a better job.

Above all, they cherished the convenience of workplace education and the fact that it was subsidized.

Bringing the education to the workers so they can take advantage of it.

It's a nice opportunity for people who can't afford to go to college.

The courses are offered on hospital grounds.

The work release time and it's free.

Nevertheless, they felt stressed by the challenge of returning to the classroom and keeping up with an academic course load while performing their regular job. This issue was dominant when students were asked what they liked least about the program.

It became too much once in a while. I became overloaded with taking care of the house, working eight hours and then a few hours of homework; sometimes it was just too much.

The long hours at home that it took to study.

I didn't have enough time to do my homework.

WEP's Meaning for Workers

WEP succeeded in tapping into an unmet demand for self-advancement among a traditionally overlooked sector of the health care labor force. Employees consistently attested to this opinion in their interview responses. The most important reasons workers gave for their interest in the program were, in order of frequency, to get a better job, self-improvement, and to do a better job.

There is a lack of mobility in the hospital; I want a better job.

I'm trying to get a promotion, to get a better job.

To learn more about medical technology.

To better myself as a black man.

To see how well I could do as a student.

Just to get back to being a student.

To go back to refresh myself from high school, I've been out thirty years.

For customers who come to my work, I want to do a good job for the hospital and the patients.

To be more efficient at my job.

To try to better my skills.

To improve my job skills and get a better awareness of what's going on and basic self-improvement.

Knowing that our jobs may change, new jobs may have prerequisites and this course might be a prerequisite.

I was doing the same thing at the hospital for twenty-two years and I needed a change; it offered a change.

I want to go on from where I am; I'm in a dead-end position and I couldn't afford to pay for classes on my own.

At a time when the country worries about declining productivity, WEP demonstrated that workers have more than enough motivation to seek upgrading. For every person enrolled, there was another who, for one reason or another did not participate.[12] The majority of these nonparticipants were disappointed about being unable to take a course or to become involved in the internship component.

Access: Who Can Participate?

Comparing participants (Ps) with nonparticipants (NPs), one finds that the latter were more likely to have attended fewer years of high school and that the former were are more likely to have some exposure to college.

Nonparticipants tend to come from lower-income households than participants. For example, proportionately more NPs live in households from the lowest income bracket; in the next highest income category a greater proportion of P households were represented than NP households.

White workers were somewhat overrepresented among the participant pool. Conversely, minority workers were overrepresented among the nonparticipants. The available evidence points to factors having to do with seniority, educational and income background, and the relatively greater structural difficulty of incorporating Tier 1 workers, compared with Tier 2 workers, in these kinds of programs. Survey responses, as well as interviews with program operators and hospital personnel, confirm that Tier 1 employees, bound by tighter work schedules and with jobs in departments more seriously depleted by personnel retrenchments, are less able to work out flexible arrangements that permit participation.

Added to this is the general finding in labor-market studies that show an interplay of education deficits, economic dislocation, and discrimination in accounting for the overconcentration of minorities in lower-paying jobs.[13] This would explain why more minorities are to be found in Tier 1, as opposed to Tier 2, jobs. There is no evidence, however, that WEP discriminatory practices were conducive to the underrepresentation of minorities in the program. Indeed, WEP staff were quite sensitive to this issue and took steps to address it.[14]

Participation rates, defined as the ratio of participants to the total interviewed population, were determined for each race and gender group. Rates were highest for white females, followed by white males and minority females, who share virtually the same rates, then minority males.

It is also the case that seniority among participants, measured by years of employment at their hospital, is highest for white females; they are followed by white males,

minority females, then minority males. In general, the race and gender pattern of participation conforms to the race and gender pattern of seniority. This was similar when comparing job tenure — years of employment in the current job — among workers.

Since seniority was a principal criterion in the selection process, it is not surprising that minorities, who entered the Massachusetts hospital workforce more recently, were slightly underrepresented. Lower average educational levels of minorities may also have contributed to underrepresentation when assessments were used to select participants. Finally, the relatively low share of minorities in the total pool of inquirers and participants, 21 percent and 14 percent, respectively, in Year 1, attest to the primarily suburban and rural distribution of WEP hospital sites.

Aside from these background characteristics, two factors were most strongly identified as explaining nonparticipation. One group apparently did not receive enough information about the program to warrant further follow-up and another group was beset by pressing family obligations that inhibited their ability to participate in the program. Other reasons concerned release time and scheduling problems. Issues related to spousal/peer support, self-esteem, and health status were of minor importance.

Evaluators had initially conjectured that the *form of communication,* whether written, oral, or other, might be instrumental in determining who ends up as a participant, but there was no evidence that any particular source of information was more important for learning about WEP. In other words, it appeared that both participants and nonparticipants learned about the program through the same information networks.

What Influenced Course Completion?

Completion rates appeared to be correlated to tier level. They are highest for admissions and discharge personnel, technical assistant/professional/technician, clerks and secretary/receptionists, all Tier 2 positions. Completion rates are lowest for housekeeping, food service, and semiprofessional workers, the first two of which are Tier 1 positions. Educational levels varied somewhat between completers (Cs) and noncompleters (NCs). The former were more likely to have had some college experience while the latter were less likely to have been enrolled in a training program prior to their involvement in the Work Education Program.

There is some indication that initial *motivation* for taking a course differed between completers and noncompleters. Giving the single most important reason for being attracted to WEP, NCs emphasized the opportunity to *get* a better job. In contrast, for Cs the most important attraction of the WEP was to *do* a better job. NCs saw WEP as an opportunity to move up the job ladder, while Cs thought in terms of improving their performance, signaling that they were relatively more content with their current position. It is not clear from the information at hand how these different perspectives may have determined the difference in outcomes.

Unsuccessful students were asked to give the most important reason for not having completed their course. Among noncompleters, the majority pointed to personal problems, alluding to family, household, and other constraints on their time and energy. Of lesser importance were course-related or job-related issues.

Participants commented on some of the program-related aspects that came into play. NCs were more likely than Cs to feel that the teacher proceeded too rapidly and that they had a hard time understanding the class discussion or keeping up with assignments. They were also less likely to feel comfortable asking questions in class. Finally, those

who did not complete their course were less likely to consider that the course material was related to their jobs.

On the whole, NCs expressed having received less interpersonal support from their families and networks at home and at work. The greatest disparity between NCs and Cs in support received was in their relationships with nonspousal family members — children, parents — course teacher, WEP staff, and work supervisor. In other words, the NCs found these persons, in the order listed, less helpful than did the Cs.

Additional insights may be gleaned from noncompleters' comments about WEP. NCs were less likely to rate their teacher and the course in general as excellent, although they had given overall positive ratings for both. NCs were less likely to feel that their WEP participation had helped them significantly in their present jobs and in improving their reading, math, and English. Also, they were less inclined to give an excellent rating to WEP.

Overview of Accomplishments

Besides the comments provided by worker surveys, WEP's accomplishments were confirmed by evidence from other aspects of the evaluation process.

Reaching Bottom-rung Workers

Outside the Boston area, where most Work Education Program sites are located, the population of Tier 1 and Tier 2 health care workers is comprised primarily of white females. This is a labor pool characterized by relatively stable employment conditions: average length of employment with the current hospital was 7.5 years, and average length of tenure in the current job title was 5.5 years. But even though they enjoy a measure of security, their standard of living is quite vulnerable, and their opportunities for advancement are limited. Two-thirds of WEP workers come from households with less than $40,000 annual income, and one of every four belongs to a family with less than $20,000 income.[15] Typically, their schooling consists only of a high school diploma or general equivalency diploma (GED).[16] Their average age is in the mid-thirties; two-thirds of them are married, and a similar number have child or adult care responsibilities. This presents a picture of a labor force threatened with stagnation in terms of career advancement. They are approaching maturity in employment experience but lack the preparation to move up the job ladder, and they are constrained by family obligations and finances from pursuing higher education.

It is a major accomplishment of WEP that it successfully reached Tier 1 and Tier 2 employees and provided an alternative path of career advancement. The rise in female participation has been one of the most fundamental trends affecting the U.S. labor force since the 1950s. WEP has shown that it is possible to devise educational programs sensitive to the needs of this expanding workforce so that the initial gains in *access* can lead to strategies for *mobility.*

Labor-Management Collaboration

WEP created several mechanisms that effectively directed program planning and implementation, including an overall advisory board with management and labor representatives from eight hospitals as well as education providers, local labor-management committees responsible for overseeing operations at individual sites,[17] and collaboratives of

professionals to advise on curriculum design and delivery. Each of these groups, assisted by WEP central staff, met regularly. Such activities demonstrated the potential for fruitful interaction between management and labor in an important service industry.

Cost Effectiveness

Compared with other programs sponsored through the Labor Shortage Initiative, the Work Education Program was quite efficient. WEP's cost per worker served was well below that of other projects offering training to Tier 1 and Tier 2 workers. WEP's average was $1,000, compared with $1,479 for non-WEP projects in 1991, and $736 versus $1,188 in 1992.[18]

Add to this the fact that WEP was responsible for servicing a sizable proportion of all unskilled workers reached by the Labor Shortage Initiative (LSI), and one can appreciate the importance of the program in the context of the state's overall strategy for upgrading workers in the industry. For example, although in 1991 it was one of five service providers funded through the LSI, WEP assisted *two-thirds* of all Tier 1 and Tier 2 employees. In 1992, WEP, as one of nineteen such programs, aided *one of every four* targeted workers. In so doing, it helped bring down the average cost for Department of Medical Security programs statewide.

Additional Accomplishments

By the summer of 1993, WEP had attained nonprofit status, allowing it to apply for grants and accept funds from charities. At least twenty-five of the employees who participated in Cycles 1, 2, and 3 received promotions at their jobs. Acknowledgment of WEP's accomplishments came from several sources. Based on its track record, the program secured additional funding from Federal Literacy funds to operate a basic skills/literacy training project at a non-WEP hospital. Subsequent to the initial grant in 1991, WEP successfully competed for renewal grants through the Labor Shortage Initiative for two more years, obtaining funds in both to expand the scope of activities.

Additional funding was approved for WEP to support the radiography interns, without which their program would have been terminated at the end of 1993. Participating hospitals also agreed to subsidize employee-interns beyond the grant period.

WEP, a finalist in a statewide competition for recognition of excellence in workplace education programs, was given extensive coverage in the local press throughout the state.

Sources of Success

The evaluation process revealed that three critical factors contributed to these achievements. WEP benefited from a highly talented and energetic program staff dedicated to the concept of work-based training for rank-and-file workers. The instructors were capable of advancing an innovative program in an environment fraught with potential conflicts among various institutional actors. The program director was particularly adept at managing the enterprise. The program leaders showed a willingness, in midstream, to experiment with new program ideas and adopt necessary modifications. In addition, the performance of the staff of the principal educational provider, which took on a risky venture, and key administrative personnel in a number of hospitals, who were genuinely committed to WEP, were instrumental in its success.

Within each hospital site, WEP operators skillfully mobilized an intricate network of

personnel who became the organizing agents for planning, outreach, and implementation. Human resources, largely on a volunteer basis, were gathered from senior and junior management and from labor's rank and file and stewards to form a collaborative relationship. In general, programs were successful to the extent that these indigenous resources coalesced around the program. In those few instances where a history of conflict or distrust reigned, where there was little parity between management authority and employee rights, programs failed to get off the ground or were less than effective.

Finally, the program would not have flourished without the existence of a motivated workforce, which seized upon an opportunity for advancement.

Impasse on a Lasting Agreement

The key strategic goal, a least from the union's point of view, was to obtain employer agreement for the creation of a permanent trust fund. By demonstrating how an educational program could raise skill levels and morale, WEP would be recognized as a type of service that merited long-term financial support. It was hoped that after the precedence of the LSI, in which employers were assessed moneys for a central fund, hospitals would continue to replenish resources for educational and training programs. A formula specifying the amount of employers' contributions to the fund would be negotiated as part of the collective bargaining agreement.

Despite a consensus by both sides that WEP was an effective program, labor and management could not reach an agreement on the creation of a trust fund. Essentially, management was reluctant to make a long-term commitment, and the WEP Advisory Board was unable to exert the necessary pressure to broker an agreement on this vital ingredient.[19] There are several reasons for their failure to arrive at consensus.

Financial Incentive

In the first place, there was no strong monetary incentive for continued hospital support. Employers were clearly willing to endorse WEP if they were obligated to contribute funds to the LSI as a way of recovering some of the resources they were required to allot to the legislation. But with the ending of the initiative, they preferred to retain control over these funds without having to earmark them for a specific purpose. In at least one case, the employer stated that it was willing to operate a WEP-style program on its own without having to share oversight functions with the union.

WEP as a Union Project

Rightly or wrongly, management perceived the Work Education Program as a union-driven project. It was therefore problematic for them to consider it a proprietary project, to contend with the resentment of nonunion employees who felt they should receive more training services, and in general to watch the union take primary credit for WEP. The union's insistence that it did not control WEP or desire to reap more than its share of recognition failed to reassure management. The uneasiness in relations between the two partners contributed to the lack of consensus on the trust fund issue. Although not formally spelled out in WEP's original set of goals and objectives, it may be said that labor viewed the program as an aid to fostering union building. Needless to say, this implicit goal was not shared by management.

From the onset, union officials saw WEP's potential for strengthening internal organization.[20] By offering a new service to members, the union hoped to enhance worker

loyalty. The existence of WEP would encourage greater participation in the union's total range of activities and affairs. It might contribute to leadership development by helping to identify employees who were interested in personal growth and career advancement. Union stewards at local sites, key in monitoring program activities, would be empowered with a new responsibility and respect if for no other reason than their ability to assist members in gaining admittance to the program.

In short, the union considered WEP not only as a provider of basic literacy or health care training but as a logical avenue into its broader program for leadership development, in which members were learning how to run meetings, engage in public speaking, and so forth. While WEP concentrates on developing skills, the union focuses on leadership development for staff, stewards, and potential rank-and-file leaders. Labor has an obligation to its members that transcends simple business unionism; and in pursuing this role, it can contribute to the well-being of the nation. Cecilia Wcislo, Local 285 president, stated, "The role of the union is to help empower workers, to see the workers as an untapped resource; in Europe, management and labor see the lack of worker education in the United States as a joke; European employers see this as an advantage they have over U.S. workers. The United States is thirty years behind the cutting-edge developments in this area."[21]

Unfortunately, management was unable to identify a corresponding set of implicit goals in WEP that would make the program equally appealing in the long run.

Raising Unrealistic Expectations

Does WEP's success have the ironic effect of raising false expectations? According to one view, expressed by a Massachusetts official who was a representative on the WEP Advisory Board, WEP must be careful about offering a carrot it cannot guarantee to deliver, that is, promotion to a higher-paying job. This had occurred with apprenticeship programs in other industries, especially the building trades. By the late 1980s the construction industry had fallen on mighty hard times and many workers in the field were unemployed. The same had occurred with those involved in training programs for dislocated workers funded through the Jobs Training Partnership Act.

There is the real possibility that there will be no job openings at the end of an educational process, leading to problems with worker morale. It is not a happy task to limit enrollment, as in state apprenticeship programs that limit the flow of candidates, but programs like WEP would have to deal with this issue sooner or later.

Job Training in an Uncertain Industrial Environment

There seemed to be no compelling agreement on the type of training that hospitals wanted for their employees. This was demonstrated at the April 29, 1993, quarterly meeting of the WEP Advisory Board devoted to the subject of education and training requirements. Several areas were identified as potentially important for worker training. Some growing technical fields, for example, magnetic resonance imaging and radiology, will require licensing, for which there will be a tremendous need to prepare workers for examination. According to one executive, hospitals will seek to expand the skills base of existing employees through cross-training policies as an alternative to hiring new personnel. Presently hospitals rely greatly on training services from equipment suppliers whose training programs are too short and superficial.

Another view argued for the importance of orientation programs to phase in worker-

students before actual course work begins, which is especially important as a strategy to overcome intimidation by the assessment process. According to another management representative, it is simply too presumptuous to try to predict training needs for large groups of employees. Between the economic recession and talk of national health care reform, the industry picture is too volatile for anyone to forecast the future configuration of labor-force needs. In the meantime, the most important step is to draw up individual training plans; for example, clerical staff being reallocated to new functions or units have to learn new computer software programs. In the public sector, where collective bargaining prevails, downsizing leads to a more senior workforce in which many employees have to learn technologies to which they have not been exposed.

It was clear from this dialogue that no strong agreement was emerging on a focused training strategy, one that would encompass all participating hospitals. It was equally obvious that hospital representatives were less enthusiastic than their union counterparts about forming a long-term relationship.

Finally, trends throughout the decade confirm that restructuring in the hospital industry continues apace. Since 1990, eighteen Massachusetts hospitals have closed. The total number stands at 81, down significantly from 1970, when there were 127 acute-care hospitals in the state.[22] We live in an environment of great uncertainty, in which projections of labor demand — quantity and quality — are extremely difficult to estimate. Despite the participants' inability to institutionalize WEP's original model, this experience can help identify the conditions for future workforce development policy.[23] It is incumbent upon the three principal stakeholders in this area — labor, industry, and government — to establish a common ground of agreement. Union members may have to consider a trade-off between wage demands and education/training programs when it comes time for contract bargaining. Labor will have to come up with more specific proposals regarding the type of training it envisions being supported by a trust fund. Labor needs to develop its thinking about cross-training and existing proposals for a more flexible workplace without sacrificing job security and quality of life within the work site.

Management will have to look beyond the short term, beyond purely economic factors, in determining the worthiness of educational programs. Employers cannot continue to argue that their exclusive role is to satisfy business criteria. The corporate sector has a social responsibility to the communities in which it operates, beginning with the clients it serves and the workers it employs.

The Worker Education Program has shown that a labor-management partnership can deliver training which meets industry needs, raises worker morale, and is cost-effective. Unfortunately, it required externally generated pressure, by the Labor Shortage Initiative, to induce industry's participation. This is where the public sector comes in, perhaps in the form of subsidies, perhaps as a "nudge" factor in pushing industry to collaborate with labor.

In the meantime, WEP has provided us with a rich experience in workplace education, one that will inform and influence future developments in the field. Worker participants sent a clear message of support for the WEP model of education. Hospital employees currently confined to the bottom rungs of the occupational ladder are eager to move up into more challenging, better-paying positions. Our society must create the conditions for a high-skilled, high-wage path toward economic prosperity and social justice. If we decide to pursue such a strategy, the WEP and similar approaches will be in the forefront of a transformative education and training system.

This article is based on interviews with hospital workers, management, and WEP program staff. The analysis draws on limited class observation, discussions at WEP Advisory Board meetings, and survey responses from 231 WEP participants. In addition, I reviewed WEP program records and reports. For detailed survey results, see the final report of the WEP Evaluation Project, Andrés Torres, The Worker Education Program: A Summative Evaluation (Boston: University of Massachusetts, Center for Labor Research, 1994). I thank Michael Bishop, Françoise Carré, Maria Estela Carrión, and Christine Hayes-Sokolove for their able assistance in the evaluation project and James Green for his comments.

Notes

1. Massachusetts Hospital Association, *Career Opportunities in Health Care* (Burlington: Massachusetts Hospital Association, 1989); Massachusetts Hospital Association, *Health Care Personnel: Avoiding a Crisis in the 1990s* (Burlington: Massachusetts Hospital Association,1989). Commonwealth of Massachusetts, Department of Medical Security,*Labor Shortage Initiative: Request for Proposals* (Boston: Department of Medical Security, 1990, 1991, 1992).
2. The Career Ladders Program at Cape Cod Hospital is a model of labor-management partnership, offering long-term occupational advancement in an economic region dominated by seasonal and part-time work associated with the tourist industry. Michael Bishop, *Opportunity Is the Rule, Not the Exception* (Boston: University of Massachusetts, Center for Labor Research, 1993).
3. This discussion covers only the DMS-funded programs operated by WEP. The organization was successful in winning other grants during and following the Labor ShortageInitiative, which ended in 1994. The WEP still directs a number of such projects.
4. See Kathryn C. Cauble, Judith D. Burnette, and S. Suzanne Roche, "Distance Learningin Retrospect," Bunker Hill Community College, March 1997, and Christine Hayes-Sokolove, "Medical Radiography Internship," in Andrés Torres, *The Worker Education Program (WEP): A Summative Evaluation* (Boston: University of Massachusetts, Center for Labor Research, 1994).
5. The distribution of program activity was as follows: 1991, 9 courses at 8 sites, 134 participants; 1992, 12 courses at 7 sites, 248 participants; 1993, 28 courses at 8 sites, 442 participants. The total of 824 participants represents enrollments, not individuals. Data were not available at time of writing to verify how many different persons participated, but our estimate based on program records is that about 400 workers took courses. This figure does not include the eleven interns who completed the intensive medical radiography component. College preparatory–level courses included precollege English 1 and 2, precollege math 1 and 2. College-level courses included English, math, medical terminology, biology, anatomy, introduction to micro-computers, introduction to health services, and computer skills.
6. Harneen Chernow, "The WEP Experience: A Practitioner's Perspective," unpublished paper, December 1994.
7. As with the union, college administration had undergone a change during the period between the WEP proposal development and implementation. Liaison responsibility was assigned to personnel who had not been involved in the planning process prior to DMSacceptance of the WEP proposal.
8. Assessments were revived in Cycle 5, 1993, with the entry of a new community college in western Massachusetts, which insisted on using standard testing.
9. Not until Year 3 would a better balance be reestablished between the needs of the two labor sectors: twenty-one courses were offered at the college level, eight at the precollege level.
10. Analysis of Year 3 activities is less comprehensive than for Years 1 and 2. There was no survey conducted of WEP participants, except for the eleven students involved in the internship component. The results of that survey are discussed in a separate report covering the medical radiography program. The bulk of evaluation activities during 1993 focused on separate studies relating to non-WEP topics: a

description of employee training programs in Boston teaching hospitals, a study of black and Latina health care workers, and interviews of students in a traditional allied health careers program at Bunker Hill Community College. The original evaluation plan, supported by the Ford Foundation, was designed to conduct a 1991–1992 two-year evaluation study of WEP.

11. Interviews were conducted with Cycle 1, 2, and 3 participants and others involved in WEP courses through June 1992. For complete results, see Torres, *The Worker Edtion Program*. A total of 380 hospital employees were reached by phone, of whom 202 were enrolled in WEP courses; 152 of these successfully completed their course(s). Not all participants were available to be interviewed.
12. In the first three cycles, 380 persons expressed interest in WEP, of whom 178 (47%) were not enrolled because they either voluntarily withdrew from the application process or were not accepted by the program. Separate records, maintained by WEP, indicate that the ratio of nonparticipants to total inquiries was slightly higher for Cycle 4 in Year 2.
13. See, for example, William A. Darity, *Labor Economics: Modern Views* (Boston: Kluwer- Nijhoff, 1984), and Susan F. Feiner, ed., *Race and Gender in the American Economy* (Englewood Cliffs, N.J.: Prentice-Hall, 1994).
14. Overall, the apparently low representation of minorities among WEP participants reflects the low numbers of these workers among Tier 1 and Tier 2 workers in the seven suburban hospitals where the majority of courses — 16 of 21 — were given during 1991–1992. For example, reports from the Federal Equal Employment Opportunity Commission, "EEO-1 Report," supplied by participating hospitals, indicate that about 6 percent of Tier 1 and Tier 2 employees in the seven suburban hospitals are African- American, Hispanic, Asian, or Native American.
15. This includes income from *all* members of the household. In the early 1990s the poverty level for a family of four was set at about $16,000, so one-quarter of WEP families were barely beyond this threshold.
16. About 30 percent have had some exposure to college in addition to their participation in WEP; less than 7 percent have completed college. The average WEP student's parents have less education than a high school degree (eleven years of schooling for mother and father).
17. Most of these committees were built on previously existing entities. WEP helped to expand their range of activities to include workplace training programs.
18. Department of Medical Security, Commonwealth of Massachusetts, *Labor Shortage Initiative Education and Training Summary: Round One and Round Two* (Boston: Department of Medical Security, 1993). These figures refer to all persons serviced, including those who were not enrolled in a program. They also cover a wide range of program models and curricular content.
19. Note that three hospitals already had a Career Ladders Program.
20. This discussion refers primarily to Local 285. In the case of Local 767, which had been operating a Career Ladder Program with its hospitals since the early 1980s, WEP was an addition to an existing configuration of training programs.
21. Personal interview, June 10, 1992.
22. Alan Sager and Deborah Socolar, "Imprudent and Impatient: Are Hospitals Closing Too Fast?" *Boston Globe*, April 27, 1997, E1.
23. The original WEP model, which was funded through the Labor Shortage Initiative, ceased to operate in 1995. It is important to note, however, that WEP continues to operate a range of education programs for Local 284 of the Service Employees International Union.