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Enid Eckstein
AFL-CIO Mobilization Department

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The health care industry and the nation's hospitals are in the throes of revolutionary change. The shift to managed care resulted in fundamental changes in the delivery of care and the structure of health care, For the past ten years, hospitals have actively been merging and creating large-scale integrated delivery systems. Employers, eager to expand market share and reduce costs, are engaged in radical reorganization of the hospital and the structure of work from which no group is immune. Physicians, nurses, technicians, and housekeepers are all affected by these changes. Hospitals are reducing their personnel, shifting work outside the hospital, and reclassifying work. Employees and their unions are responding to these changes at the bargaining table, and the State House, and are actively building coalitions to advocate for quality patient care and for employment standards to secure their jobs.

A leading, nationally recognized public hospital, announces its intention to merge with a private teaching hospital. For the next two years there is a major public debate over the merits of the merger, its impact on the health care delivery system, and the effect on the more than four thousand workers at the institutions.

Hundreds of hospital workers and community residents pack a community auditorium. Weeks before, hospital trustees announced their intention to sell the hospital. Everyone is anxious. They are there to hear representatives of several major health care corporations discuss the advantages of affiliation with a specific network. Two of the contenders are for-profit national hospital corporations and the third is a major area network of hospitals.

Several dozen laundry and housekeeping workers gather in a conference room in a midsize central Massachusetts hospital. A human resources staff person nervously awaits the arrival of a hospital vice president. Within minutes, they hear about the contracting out of thirty-two jobs. Each of the affected workers has a minimum of seven years of service in what for many of them is the most secure job they have ever held. Hospital administrators tell them that they will be allowed to reapply for their jobs but that the new contractor will set different wages and benefits.

Enid Eckstein, former staff director, Service Employees International Union 285, who was instrumental in the formation of the Boston Medical Center, is a member of the AFL-CIO Mobilization Department.

A major for-profit hospital corporation announces its intention to purchase a medium-size suburban hospital. The corporation, with a controversial record of providing free care, seeks to gain a market foothold in the state. The company announces that it will spend $3 billion to create a network in the state. The company makes many promises to the community.

A hospital lays off forty full-time nurses. On the same day the administration posts sixty part-time nursing positions, explaining to its nurses that the hospital needs "flexibility to manage."

Such scenes are taking place across the country. Hospitals are closing, merging, or selling out to for-profit corporations. Smaller community hospitals either close or become part of larger health care networks. Major free-standing hospitals seek partners and merge. Major for-profit chains increase their control over the health care market. The merger and acquisition frenzy that shaped industry in the 1980s has come full force to health care in the 1990s. Health care procedures, once delivered within the confines of hospitals is increasingly being delivered outside the confines of the hospital.

How the industry is changing, how work is being transformed, and how both workers and unions are responding to this rapid transformation is the subject of this article. The Service Employees International Union (SEIU) Local 285 represents thousands of hospital workers who are confronted with these changes. Every day health care workers struggle and respond to the transformation of the industry. At the same time they maintain the hard-fought gains won through unionization.

The Roots of Change: Why?

The radical changes in health care are part of an ongoing transformation whose roots are in the 1960s. President Lyndon B. Johnson's Great Society expanded health care to the nation's poor and elderly with the introduction of Medicare coverage for the elderly and Medicaid coverage for the poor. By making Medicare available to the large segments of the population that had been denied care and by offering to reimburse doctors and hospitals for all their costs, including capital expansion, the federal government encouraged unprecedented growth in the number of hospitals and delivery of health care regardless of cost. The lack of a national health care plan encouraged each hospital to spend large sums of money on duplication of costly equipment. By the early 1970s, health care costs skyrocketed. National spending rose from 38 percent to 43 percent of all health care.[1]

The government, alarmed by its high medical bills, made reining in health care costs a top national priority. Beginning in 1983, the Medicare reimbursement system switched to a fixed price per disease diagnosis, designated as diagnostic related groups (DRGs) covering 468 specific diseases. Each hospital was given 468 categories into which all patients must fit. Each DRG had a preset price tag so that the hospital knew how much it would be reimbursed for each patient. In the past, hospitals billed Medicare for all patient-related costs, including depreciation, interest costs, and profits, after the facts. Under the old system, a hospital could bill Medicare for any procedure and allocate costs as long as they were directly or indirectly related to the provision of care. In contrast, under the DRG system, each hospital is paid a fixed price per patient according to the patient's diagnosis, regardless of actual cost. Under the old system, it was

difficult for hospitals to realize a profit on Medicare. The new prospective payment system provided hospital administrators with an incentive to reduce hospital costs. Since they knew the reimbursement rate up front, smart administrators could make a profit if they could cuts costs. DRGs provided an incentive to reduce hospital stays, discharge patients early, dump less desirable patients with multiple problems, and reduce the number of procedures offered to patients. Government policy shifted emphasis from expanding care and capacity to controlling costs.

Administrators used the new system to wage war on workers and existing standards. By reducing the number of patient days, hospitals began to reduce the workforce. Within a few years the number of full-time-equivalent hospital workers dropped by 145,000 from the 3.2 million of 1983, according to American Hospital Association statistics.[2] The new system managed to slow the rise in hospital costs, and admission rates dropped. While the cost-reduction drive was successful, the new cost cutting was a major boon for hospitals, which continued to expand services and invest in new construction. Nineteen eighty-four was a record year for hospital profits.

Other Pressures to Reduce Costs

At the same time, the private sector sought to reduce its escalating health care bills. Employers endeavored to reduce costs by attacking employee health care plans, building in controls by requiring preadmission testing and second opinions. Many employees moved away from traditional indemnity, fee-for-service, plans because they became too expensive. Many employers introduced a health maintenance organization as an option. Workers accustomed to unlimited choices suddenly found their health care determined and limited by costs. Employers often passed on increased costs in the form of higher employee co-pays. Many important union contract battles were fought over unionized workers being forced into co-payment for health insurance or to move from an indemnity plan to an HMO. As costs increased, employee take-home pay was reduced.

A Move to Managed Care

The drive to cut costs escalated with the rise of health maintenance organizations and others pledged to "manage" care. In a 1988 survey, 71 percent of insured Americans were in traditional fee-for-service plans and 29 percent in managed care. Seven years later those numbers were reversed: at the end of 1995, 30 percent of covered Americans were in fee-for-service plans and 70 percent in some form of managed care. Also by the end of 1995, more than 56 million Americans were enrolled in some form of health maintenance organization. An additional 70 million were in more traditional insurance plans with some features designed to manage care.

The term "managed care" refers to a wide range of organizational and payment changes that are intended to eliminate unnecessary and inappropriate care and reduce costs. Most such plans call for the formal enrollment of patients in a managed care organization. Managed care payment arrangements also vary widely, ranging from fully capitated — full risk — plans to fee-for-service — primary care case management — plans. In a fully capitated plan, the HMO receives a set fee, usually monthly, for each enrollee regardless of the type or amount of services an individual may need or use.

Shifting Power from Provider to Payer

The move to managed care represented a radical power shift in the health care payment structure. The traditional fee-for-service system placed power squarely in the hands of the health care providers. Physicians and hospitals could make money by providing as many services as possible by increasing the fees for them and keeping labor costs down. Hospitals expanded and dominated the market. Under a managed care system, power shifts from the providers to payers, employers or purchasing groups, because they negotiate a flat "per head" fee for all services provided to each person covered. Under this system, the best way for hospitals to make money is to minimize, not maximize, services and to cut costs wherever possible. The result is a new cutthroat competition based on lowering costs.

To survive financially under a payer-controlled system, hospitals have a hard time remaining independent entities for they must reduce costs and guarantee their share of the market. By networking with other hospitals, they have the potential to reduce unnecessary duplication of services, penetrate new geographic markets, and maintain their market share. Under an increasingly capitated system, physicians and hospitals make money by maximizing their patient base and providing as little service as possible to these patients at the lowest possible cost. Combined with pressure from investors to maintain high profit margins, the move to capitation has led to a new wave of corporate mergers and cost-cutting measures.

Hospitals maximize profits by reducing hospital stays and shifting work to other settings where overhead is lower. The incentive is to deliver care at the lowest rung of the delivery system. If it can be provided in an outpatient setting, insurance reimburses only at that rate. If a patient can be discharged and treated at home, insurance reimburses only at that rate. Hospital utilization rates are declining nationwide. In 1990 the average length of stay was 6.7 days per admission and in 1996 that figure was 5.6 days. Just ten years earlier it was seven days. A good case in point is the number of days a mother is hospitalized for the birth of a child. Twenty-five years ago a woman remained in a hospital for four days for a normal delivery. By the early 1990s, two days was common. In many hospitals it is now twenty-four hours after the birth of the child. In some cases discharge is eight hours after delivery.

As the length of hospital stays decreases and the number of beds declines, work is being shifted out of the hospital. As patients are discharged earlier they are increasingly sent home, where they require follow-up or outpatient care. Surgery, which several years ago required a two-night stay, is increasingly performed on an outpatient basis. This is reflected by the drastic rise in hospital outpatient visits from 80 million in 1990 to 128 million in 1995.

Hospitals are merging at an unprecedented rate and forming integrated delivery systems in which hospitals, doctors, community health centers, outpatient surgical centers, home care agencies, and other health providers form one giant entity. The hospitals claim that by joining with others they are seeking greater economies of scale and better access to capital to finance other ventures. In the last three years there have been more than one hundred mergers nationally. At the end of this consolidation phase, most major urban centers will have no more than two or three major systems in place.

The Failure of National Health Care Reform

The American public has long been demanding an overhaul of the nation's health care system. Its costs have been rising faster than anything else, accounting for 13 percent of the gross national product. During the 1992 presidential election, everyone talked about reforming the nation's health care delivery system. President Clinton, whose campaign platform promised major change in it was overrun by powerful industry lobby groups. Health care reform was "dead on arrival" when it finally made its way to Congress. Absence of a federal policy has created a vacuum that has been filled by managed care companies, insurance companies, and state legislatures eager to reduce their own health care costs. Dr. Samuel Thier, chief executive officer of Partners HealthCare System, commented that "the system is not driven by any commitment to broadening access to care. There is little incentive for managed care companies to serve the uninsured."[3]

Individual states, in the absence of national policy, have taken matters into their own hands. Numerous states, including Massachusetts, adopted their own approach to market reform. In 1991, the commonwealth deregulated much of the health care environment. The state encouraged selective contracting, which gave even more power to HMOs and insurance companies. Such contracting enables payers to negotiate discounted rates from providers in return for an expected volume of patient visits. Under this policy, a particular HMO could contract all its maternity coverage to one or two selected hospitals in a geographic area. All its patients would deliver their babies only at those hospitals. As a result, HMOs could determine which hospitals would survive and which would languish. The increased power of HMOs was evidenced by the ongoing struggle between New England Medical Center Hospital and Harvard Pilgrim when the HMO threatened to squeeze NEMCH by refusing to pay for its patients to be treated there.

At the same time, state government has encouraged hospital closings as the main hospital cost-containment strategy. Hospital closings disproportionately hurt urban poor communities. National evidence shows that urban hospital closings are likeliest in poor communities where unmet health needs are already greatest. Massachusetts has seen hospitals closed in Fitchburg, Worcester, Dorchester, and Lynn.

Pressure on Public Hospitals.

The changing market structure disproportionately squeezes public hospitals which, with public health care systems, provide an important safety net for millions of uninsured and underinsured patients. At a typical hospital, more than half the inpatient days are covered by Medicare while only 10 percent are covered by Medicaid. Most of the remainder are covered by private insurance. At a typical urban public hospital, 45 percent of patients are on Medicaid, and 20 percent pay for themselves. Self-pay includes those with no insurance, which makes it unlikely that the hospital will collect the money. This pattern is even more pronounced for outpatient visits to public hospitals, where 37 percent of visits are self-pay and 32 percent are reimbursed by Medicaid.[4] As a result, costs for treating these patients are either uncompensated or undercompensated so that public hospitals and clinics have had to rely on a variety of means to cover them. These include cost shifting to insured patients and subsidies from federal, state, and local government bodies.

Across the nation, local governments are under pressure to trim local budgets. Many local politicians believe that their governments should get out of the health care business. Local advocates for divestment are often joined by administrators who feel that public hospitals are hindered by restrictive laws that regulate their activities and restrict their ability to compete. In a further turn of the screw, government cost cutters are reducing payments to teaching institutions for the inner-city poor. Last year the University of California at Irvine lost 65 percent of its subsidies although its patients did not disappear. The hospital, giving up, began to negotiate with a for-profit chain to lease the hospital. In the last few years many local governments privatized their hospitals, cut services, or contracted out the management to a private corporation. Others are still in the process of exploring alternative options. Over the past five years virtually every Massachusetts public hospital has closed, transformed its governance structure, or been privatized. Among those affected are the following:

Hunt Hospital (Danvers): Closed
Bridgewater State Hospital: Privatized
Springfield Municipal Hospital: Sold
Worcester County Hospital: Sold
Boston City Hospital: Merged with Boston University Hospital; privatized
University of Massachusetts Medical Center (Worcester): Merged with Worcester Memorial; privatized
Hale Hospital (Haverhill): Engaged in ongoing discussions about its future

While the bottom line for individual communities may improve with divestment, the outlook for community-based health care is unclear.

Managed Care Comes to Medicaid

A major pressure on public hospitals is the shift of Medicaid to managed care. From 1981 to 1993 the number of public hospitals declined by more than 25 percent. "The mood of the country right now is that nobody wants to increase taxes," reports Ms. Burch of the Public Hospital Association. "There is a strong sentiment business does things better than government does and that spills over to people's attitudes toward public hospitals. I think people are questioning how much we need public hospitals."[4] The federal government has turned over Medicaid regulation to the states, many of which have instituted some form of managed care to administer their plan. This approach uses networks of selected providers and institutions to provide care. Private hospitals seeking to increase their patient base are eager to recruit the managed care Medicaid population. As a result, public hospitals often have a hard time maintaining their traditional historic patient base. Many are incapable of competing because their facilities are less attractive and their costs higher than those of private hospitals for a variety of reasons. When New York instituted a state program with state incentives, 300,000 Medicaid recipients joined Medicaid managed care programs. Only 8 percent joined the public health care system. Private hospitals where beds remain empty are recruiting Medicaid patients they turned away just a few years ago, forcing the public hospitals to compete with them for patients who have been their traditional base.

Across the country, local governments are working hard to dump their public hospi-

tals, seeking either to sell them off or to privatize them. These moves raise considerable serious concern over the ability to take care of the nation's uninsured poor. The California experience is instructive; hospitals subject to intense price competition and great fiscal pressure from Medicare and Medicaid reduced their uncompensated care load compared with hospitals facing less competitive pressure, according to a study of private hospitals.[5]

Merger Mania

Hospitals faced with excess capacity, losses from public programs, and managed care seek to maintain their financial stability. One strategy they have pursued is collaboration through mergers, acquisitions, and joint ventures. Merger and acquisition activity totaled $20 billion in 1994. In the first five months of 1995, U.S. health care mergers worth $13 billion had been announced in health services alone, compared with the $7 billion spent in the same 1994 period. Countrywide there have been more than one hundred hospital mergers to date. In Massachusetts the race to merge has been under way for a number of years. Its official kickoff date was 1993, when the Brigham and Women's Hospital and the Massachusetts General Hospital announced their merger and intention to form Partners HealthCare System. Three and a half years later its network includes 16,000 employees and 754 primary care doctors in eleven hospitals throughout Massachusetts and others on the drawing board. Since then numerous other hospitals have formed partnerships and their own networks for survival. Those institutions which did not rush to the altar are finding it difficult to survive as free-standing entities. Virtually every Massachusetts hospital has entertained and engaged suitors, as witness the following listing, which outlines some of the major market realignments of the past few years. Unnamed hospitals may be part of smaller regional systems or, like Quincy Hospital, may be independent. However, because these mergers occur so frequently, this inventory at the time of writing is bound to change almost daily.

Care Group
Beth Israel
Deaconess
Deaconess Waltham Weston
Deaconess Nashoba
Mount Auburn
New England Baptist
Addison Gilbert
Beverly

AtlantiCare Medical Center
Lynn

Partners HealthCare System
Massachusetts General
Brigham and Women's
Massachusetts Eye and Ear
Anna Jacques

Emerson
Lawrence Memorial
McLean
Malden
North Shore Medical Center/Salem
South Shore
Whidden
Winchester

Berkshire Health Systems
Berkshire Medical Center
Fairview
North Adams
Hillcrest

Columbia/HCA
MetroWest
Neponset Valley systems

Lifespan
New England Medical Center
Newport Hospital

The Growth of For-profit Medicine

The 1990s saw the expansion of for-profit health care systems. Companies like Columbia/HCA Healthcare Corporation, OrNda, Tenet, Quorum, and others began to dominate the scene. In the last three years, with Columbia/HCA leading a revival, more than one hundred community hospitals have been taken over by the profit-making industry. This wave of conversions has become the biggest transfer of charitable assets in history, nearly $9 billion in all.[6] In the late 1980s and the 1990s, Columbia/HCA began to build its empire, which has grown to more than 344 hospitals that treat more than 125,000 people a day.[7] Columbia earned $1.5 billion on sales of $19.9 billion in 1996.[8]

Columbia, with 285,000 workers and 1996 revenues of $230 billion, the world's largest health care corporation,[9] has come under intense government scrutiny for alleged Medicare fraud. In March 1997, the government raided its El Paso office, and in early July, FBI and other federal agents served thirty-five search warrants in seven states, launching a major investigation of potential Medicare overbilling and fraud. In one case Columbia is charged with overbilling $1.77 million.[10] In another investigation, officials are determining whether a maze of hundreds of corporate subsidiaries acquired by Columbia were used by some of its hospitals to obtain unwarranted federal reimbursement deceitfully.[11] Richard Scott, the chief operating officer, resigned as a result of the probe.

Columbia and other companies began to buy up hospitals throughout the South and Southwest in the late 1980s and 1990s. As the competition to survive grew more intense, companies with deep pockets quickly moved in. Communities with struggling hospitals became easy targets for purchase or takeover by entities like Columbia. A community that had received no tax contributions from the local nonprofit hospital was

often convinced to sell its institution or enter into a joint venture with Columbia. In turn it would receive local taxes and Columbia would establish a foundation to respond to community needs. For each of these communities the result was far from that. Within a few years of Columbia's conquest, the hospitals often reported a decrease in care of the indigent.

For-profit health care burst on the Massachusetts scene in 1995. Columbia announced its intention to purchase MetroWest, the former Leonard Morse Hospital, and Framingham Union Hospital. Despite organized opposition of the academic medical community and the public, several large public community hearings, and legislative hearings, the deal went through. In signing the document to purchase MetroWest, Columbia announced its intention to spend $3.5 billion in Massachusetts for "network acquisition." Responding to the MetroWest takeover, Rhode Island activists and legislators have won a ban on any further incursions of profit-making hospitals in their state. Current antitrust law has proved ineffective and incapable of reigning in the power of these giants. It is impossible for a small community or public hospital to compete in this market. For many hospitals the fundamental question is not whether to join a network but which network can survive.

Concern over the increase of for-profit health care stems from general concern about care delivery. When a company like Columbia diverts funds and overbills, the quality of care is apt to be affected. When the corporation announced the sale of its home care business, SEIU responded by releasing "Acute Need," a report revealing how bare-bones staffing at Columbia's largest hospital, Sunrise in Las Vegas, contributed to its inability to feed stroke patients on time; to IV dressings remaining unchanged for a week or more; to errors in delivery of IV medications and fluids increasing the risk of complications and infections; to inability to follow doctors' orders; to some patients not being bathed for three days running.[12]

Workers and Unions Respond to the Changing World

One doesn't need a crystal ball to see that shorter hospital stays, mergers, and closings have major impacts on health care workers. Those who once thought the system was stable and their jobs secure are learning about insecurity firsthand. Health care workers in every sector — hospitals, HMOs, nursing homes, and home health care — are on the front lines of an industry in change. Top-level management discuss plans and potential deals behind closed doors. Rumors fly through workplaces. Employees often learn of pending changes through the media.

Hospitals are cutting costs by reducing the number of full-time-equivalent positions. Layoffs are the most common form of cost cutting, but hospitals employ a number of other strategies.

- Reducing the number of health care jobs;
- Converting permanent full-time positions to part-time and contingent positions;
- Transferring services from inside the hospital environment to less costly community-based settings;
- Restructuring work performance and job design;

- Changing hospital governance;
- Attacking working conditions and standards;
- Challenging the union's existence.

In many areas of the country there is little union organization among health care workers. In those areas where they represent hospital workers, unions have been in the forefront of responding to these changes and to overall industry restructuring. Without a union, employees are left with little protection. As in any situation of monumental change within an industry, there are varying approaches unions and their members can employ in their fight to retain jobs. Union strategies can best be categorized in the following areas:

- Defensive fights over job retention;
- Fights over access to care and quality care;
- Control over skills and maintenance of skill levels;
- Maintenance and expansion of the union's market share and its ability to control standards within the health care environment.

Hospitals Take the Offensive

There was always an implicit social contract for hospital workers. Although a hospital job never paid a great deal, it was fairly secure. Employees worked hard and were rewarded with a paycheck, decent benefits, and a clear sense of protection. Hospitals, unlike manufacturing facilities, were not going to move overseas. Health care employees, watching other workers being laid off, believed that their jobs were safe.

Cost Cutting

With the arrival of the 1990s, the very fabric of this agreement was ripped apart. Hospital work was no longer secure! As hospitals seek to slash costs, their first target is labor. As the number of beds is reduced, patient stays are shorter, and more care is delivered outside their walls, hospitals require less staff. If patients are discharged from hospitals two days earlier than ten years previously, there are six fewer meals to prepare per patient, fewer rooms to clean, fewer tests to administer, and less laundry to process, there is less need for nurses, dietary workers, technicians, housekeepers, and people providing specialized and support systems.

Hospital jobs used to dominate the industry. In 1970, two-thirds of all health care workers were employed by hospitals. Today that population has dropped to 50 percent. The growth of hospital employment will slow in the next ten years, and hospitals' share of all health care jobs will be closer to 40 percent of the workforce. By the year 2000, experts predict, hospitals will cut 80,000 additional beds and reduce the number of inpatient staff.

Limited surveys and data demonstrate that staffs are being downsized. A 1994 survey of 1,143 hospitals and 41 health care systems conducted by Deloitte and Touche showed that 58 percent of hospitals had cut their line workers and 49 percent anticipated doing so over the next five years. The most basic form of health care force reduction is the

traditional layoff. Yet many other forms of job attrition are not reflected in these figures. Many hospitals contract out existing services like food supply, cafeteria, laundry, housekeeping, and clerical work to private profit-making corporations because administrators believe that contractors can provide them at a lower cost than their current rate. A contractor may offer jobs to the displaced workers, but at a radically reduced rate with few benefits. In recent years contracting out, which was once restricted to food service, laundry, and dietary departments, has escalated and is found at every level of hospital services. Laboratory services, direct patient care, billing, and secretarial tasks can all be contracted out. Although contractors can often offer them lower costs, hospitals can encounter problems with staff turnover and the quality of work provided. Some administrations have reinstated previously contracted-out services in their hospitals.

Another major change involves employers that eliminate a set number of full-time jobs, then simply reconfigure them as part-time arrangements that usually do not pay employee benefits. It is estimated that more than 40 percent of health care jobs are now filled by contingent workers, 10 percent contract and 29 percent part time.[13] While the increased use of contingent workers may be cost-effective by hospital standards, it can have an adverse impact on continuity of patient care.

Restructuring Jobs

Today a major focus is on reinventing or redesigning hospitals. Reengineering, which regards health care as a series of integrated processes that can be made more efficient, had formerly been limited to manufacturing but began to find its way into the hospital in the late 1980s. Health care analysts and consultants who have studied the provision of health care describe the field as a landscape of inefficiency, waste, and poor services. Chip Caldwell, CEO of West Paces Ferry Hospital in Florida, maintains that "health care, like the manufacture of cars, can be viewed as a complex production system. Transporting medical records or referring patients to specialists are all processes that can be broken down."[14] Delivery of care, the experts point out, is broken into too many fragmented tasks — housekeeping, food service, admitting, nursing, and so on. Some studies indicate that one patient admitted to a hospital is seen by more than fifty-five employees.

Over the years management experts have tried many approaches to redesigning the hospital, the most popular being patient-focused care, which involves a fundamental restructuring of work. Resources, processes, and staff are organized around patient bedside care units rather than centralized functional departments or units. The plan is based on work design and creates caregiver teams, cross-trains staff and reduces the number of classifications, makes greater use of clinical protocols to standardize care, and decentralizes most services. A 1992 survey of 311 hospitals shows that 31 percent had implemented a patient-focused care program and another 16 percent planned to do so over the following year.[15] A few basic concepts are at the core of patient-focused care.

- Caregivers are cross-trained to provide 80 to 90 percent of services patients need, including traditional bedside nursing, X-ray films, and lab work. Appropriate X-ray and lab equipment is deployed to the unit so that patients rarely leave the unit and almost never require scheduling or transportation.

- Caregivers admit their own patients and, in addition to taking charge of medical coding and billing, change linen, pass trays, and perform similar tasks.
- A protocol-driven, predefined total care plan acts as the program for the team. Nurses chart or document only unexpected or unusual changes rather than the totality of a case. Documentation time is radically reduced and medical records are totally computerized. Protocols can't rack such information as length of stay and average costs. Some physicians object because they believe that this type of structure limits their authority.
- Long-term sustainable reductions in personnel are possible.

At the heart of this effort is a program to cut labor costs, streamline care, and increase competitiveness. As one expert, Philip Lathrop, a vice president at Booz Allen, a major reengineering firm, describes it, "The huge savings enabled by the patient-focused hospital will require us to redeploy and downsize many centralized functions such as housekeeping, medical records, and routine areas of lab and radiology."[16] To do this effectively, management must combine many tasks into a few, utilizing several basic forms.

Restructured Teams

This entails using multiskilled teams to perform ancillary tasks by combining skills and tasks previously performed by a number of licensed certified and unlicensed uncertified occupations into one generic job title. Specific tasks and composition of these teams vary according to the requirements of a specific hospital, patient population, and worksite design. Kaiser Bellflower (California) Hospital restructured its staff through formation of the following teams:

Service partners. A cross-trained position that combines housekeeping, dietary, supply, transport, and nursing assistance duties. Their primary responsibility is housekeeping, but they are trained in transport, dietary fundamentals, and other comfort care skills that will enable them to assist the bedside team.

Technical partners. Cross-trained technical partners incorporate nursing assistant and lab and EKG technician duties. In addition to their duties as a traditional nurse's aide, technical partners draw blood and administer electrocardiograms.

Processing partners. These people perform unit clerk duties but are also cross-trained in nursing assistance skills to lend helping hands to the bedside team.

Licensed practical nurses. Unlike some patient-focused models, this plan retains LPNs.

Registered nurses. These nurses, who perform traditional R.N. tasks, are also cross-trained in respiratory therapy, drawing blood, and taking EKGs, all tasks accomplished at the bedside.[17]

While the extent of the move to patient-focused care is unknown, many hospitals are availing themselves of job redesign to cut labor costs and replace highly trained professionals with less skilled employees. A number of others have tried to pare costs by reducing the number of registered nurses and replacing them with less capable personnel, an approach known as de-skilling.

De-skilling

De-skilling can be defined as the process by which a job is analyzed and quantified. Those tasks which can be reassigned to a less skilled employee are so designated. De-skilling has received most attention in connection with registered nurses. Hospitals concerned with reducing R.N. costs have restructured their staffing mix and created whole new sets of job classifications with titles like patient care technicians (PCTs), nursing technicians, nursing extenders, and so forth. These jobs incorporate many tasks that were previously performed by registered nurses. Feeding, changing, dressing, and bathing patients, taking vital signs, and other bedside tasks are routinely performed by PCTs. Only a few years ago, many hospitals staffed units with 90 percent registered nurses and only 10 percent ancillary personnel. In 1995, the American Hospital Association reports, 97 percent of hospitals were using some form of nurse extender.

This is a radical shift for nurses whose labor was much in demand in the 1980s. Hospitals established staffing patterns that relied heavily on registered nurses and limited the role of licensed practical nurses. LPNs, who had previously been allowed to perform many tasks, found themselves excluded from many parts of the hospital with limits placed on what they could do. Many hospitals laid off LPNs and replaced them with R.N.'s. By the late 1980s a serious nursing shortage had been created. Management responded by radically increasing the rate of pay, benefits, and status of R.N.'s. In a large number of cities, R.N. salaries increased by 20 percent and nursing schools were suddenly flooded with applications. The late 1980s and early 1990s saw a huge increase of students in nursing programs, which shortly thereafter led to a major glut of registered nurses. Administrators of hospitals, faced with mounting costs, and especially desirous of curtailing nursing costs, examined their staffing mix and the specific tasks performed by R.N.'s.

In 1995 the Institute for Medicine issued a study stating that the "R.N. skill mix appears to be dropping in many settings from a range of 76–100 percent to a range of 52–79 percent."[18] Many workers who deliver patient care at the bedside have been cross-trained to perform these tasks, for they may previously have been housekeepers or transport workers. There is no set state requirement for certification of patient care technicians. Training and preceptor programs vary from institution to institution: one hospital may provide eighty hours of training and others several months.

Unions representing R.N.'s have been in the forefront of the fight against de-skilling. Legislation has been enacted in some states to limit the role of the PCTs, which has a major impact on the delivery of quality care. An R.N. is trained to recognize subtle differences in a patient's condition that can be important to an eventual outcome. Patient care technicians operate under the supervision of a registered nurse who may not have sufficient time or staff to monitor a PCT's work or a patient's condition. PCTs, who are not supposed to work on their own, are expected to report changes in a patient's condition. But proper assessment of change is often a matter of clinical judgment gained through education and training, not something that can be learned in a six-week training class. Nurses' unions and associations have sought to define and limit the role of PCTs through collective bargaining, state licensing boards, and state legislatures. The ever increasing use of patient care technicians and decreasing reliance on registered nurses is of great concern to the nursing profession.

The other considerable aspect of job restructuring is the multitasking approach in which several jobs are made into one by combining the duties of multiple departments under one title. As medical technology and expertise expanded during the past twenty

issues. Bargaining in the 1980s concentrated on improving wages and status for health care employees, especially nurses. The other critical thrust, a fight over staffing and quality of care, enabled local unions to make individual breakthroughs in staffing language.

As the newly created climate began to emerge, the accepted bargaining approach was limited. Administrators, as always, resisted attempts to bargain over quality of care and staffing. Hospital management tried to subvert existing union structures through the introduction of numerous total quality management (TQM) programs. Those in charge tried to convince union members that they could solve many of their concerns through TQM problem solving rather than established union procedures. Union members often problem-solved themselves out of a job. While workers may have been wooed into cooperating with management to solve hospitalwide difficulties, it soon became clear that those in power had only one goal in mind: cutting costs, especially labor costs.

Existing contract language and labor law could not anticipate managed care, hospital mergers, and for-profit conversions. Local unions recognized that the fight would take place on many fronts. They quickly developed new strategies to deal with multilocations, successor employers, multiemployers, mergers, privatization, and accretion of nonunion areas. Local union representatives, realizing that they had to become experts on mergers if they were to survive, versed themselves in all aspects of merger law and forms of governance and financing. Unions began to put forward language that would protect members.

Changes in governance put unions into the political and legislative arenas. Whether it was the Boston City Hospital/Boston University Medical Center Hospital merger, which required both City Council and state legislative approval, or the sale of MetroWest, which required the approval of the state attorney general's office, unions have had to mount a large-scale political campaign. Local unions fought to make survival or successorship of the union and its contract a term and condition of sale. Union members began to understand that meaningful job protections and security clauses were harder to win than wage increases.

The Fight for Job Security

Unions are in the forefront of the fight for job security. They seek to develop contract provisions that will minimize job loss, ensure members' future job security by giving them access to new jobs created by the employer and redesigned jobs, and protect laid-off members, which can take several forms.

- *No-layoff clauses.* Some hospital employers and unions have agreed that there will be no layoffs for current employees under the terms of the agreement. In some cases unions have won this protection as a trade-off for no wage increase or a willingness to participate in job redesign.
- *Severance pay.* Some unions have negotiated quite generous severance packages for members as a disincentive to layoff.

- *Transfer rights to other network institutions.* In the event of a merger, employees would have the right to transfer to other institutions within a network whether or not they were union ized. This could cover all facilities within a network, including extended-care facilities and home care programs.
- *Job security provisions.* 1199 New York and the League of Voluntary Hospitals in New York negotiated a model program. In the event layoffs are unavoidable, employees receive assis tance by means of training programs to learn new skills, supple mental unemployment insurance benefits, and ability to transfer to other hospitals, for example.

Bargaining over job redesign. The best approach to protecting members' jobs is to ensure that they can fill the new jobs that are being created in the hospital environment. In some cases management presents the union with newly created jobs and the union bargains about it. In other cases management and the union establish ground rules that govern negotiations over work restructuring. The Service Employees International and other unions have established general principles that include the following.

1. The union must have full participation and an equal role in the work reorganization and job design process
2. The process should be consistent with the collective bargaining agreement and should be bargained, not imposed.
3. Job security guarantees must ensure that work reorganization and job redesign do not lead to layoffs.
4. Redesign should include a commitment to training workers for the new jobs.
5. A placement process for workers who are unable to qualify for new jobs.
6. Seniority rights must be protected.
7. Members should maintain the same or greater rate of pay if moved to a restructured job.
8. Cost savings or other benefits derived from the process must be shared equitably by all participants.
9. Staffing commensurate with quality patient care must be maintained in restructuring of the workplace and jobs.
10. No contracting out or part-time jobs as a result of restructuring.
11. Protection of the unions' bargaining unit.[19]

Bargaining for Quality Care

Health care workers know firsthand that many of the changes created by managed care have undermined both their ability to deliver good care and the quality of care. As workers and consumers of health care, health care personnel are in a unique position to speak out for quality care. Unions have long supported (1) an end to gag rules and (2) patients' rights to full access to a health plan and doctors' rates. Local and international unions have been in the forefront of the fight for access to affordable quality care. Health care workers are also involved in the fight to ensure that the caregivers who deliver the services can do so in a professional, dignified manner. Health care workers bargain and fight to maintain a high-quality work environment despite all the affronts on their ability to perpetuate one. This includes proper training and certification of direct caregivers, proper staffing ratios, specific R.N. and LPN ratios to ancillary staff, and limits on the use of per diem and contingent workers to ensure ongoing continuity of care and proper health and safety protections for employees

Unions cannot win these changes by themselves. They have to join together to build broad-based community organizations and coalitions to fight for a truly patient-driven, not profit-driven, health care system. Some consumer and community coalitions have been disconnected from the concerns of health care workers, at times playing off their needs against community and consumer needs. Building coalitions that bridge community, consumer, and worker concerns is a must to mount a movement to regain control of the health care system.

Need for Policy

The lack of national policy has opened the door to corporations, for-profit med-icine, and meganetworks of health care providers. A long-term solution that restructures American medicine under a single-payer plan would provide affordable health care to all and remove the profit motive. While that may be the long-term answer for what ails the health care system, it is necessary to address a number of more immediate policy issues.

- *Merger protections.* Existing federal antitrust law has not had an impact on health care mergers. Legislation must be adopted to meet the following needs:
  - Guarantees of affordable health care to a community;
  - Full disclosure to the public of all terms and conditions of a merger;
  - Successorship protections to workers in union contracts;
  - Consumer protections;
  - Maintenance of services to the community;

- *Ban on for-profit medicine.* For-profit hospitals and HMOs are more concerned with profit making than with providing quality care. The lack of a national plan has forced states to take action into their own hands and several, like Rhode Island, have sought to limit or ban for-profit companies.

- *Quality of care protections.* There is an abundance of horror stories regarding one-day mastectomies and twenty-four-hour maternity stays. The accidental chemotherapy drug overdose of a *Boston Globe* columnist at Dana-Farber Cancer Institute points to the need for greater control over quality. Various states have passed legislation requiring minimum lengths of stay for maternity and mastectomy patients.
- *Union protections.* Health care workers are frequently the best advocates for quality care in the managed care environment. They know first-hand what is happening on a hospital floor. Doctors who have spoken out against substandard care have found themselves censured and gagged by health maintenance organizations. Doctors, many of whom cite managed care as the precipitating cause, have begun to organize in several states. Unless workers are protected by a union they cannot speak out against the abuses of managed care. Mergers and changing hospital governance should not be a green light for the industry to go after unions. As hospitals merge, larger bargaining units are created. Existing labor law has proved inadequate to cope with the changing industry. Legislation must be enacted to require the hospital industry to pay its share of retraining for the health care workers of the future.
- *Security funds.* In the 1970s and 1980s, the U.S. auto industry faced foreign competition, and hundreds of thousands of workers were laid off for long periods. The federal government, after intense lobbying, passed the Trade Readjustment Act, which provided supplemental insurance benefits and generous retraining funds for displaced workers. Similar legislation should be enacted to cover health care workers.
- The legal right to union representation should be extended to private-sector interns and residents, who are currently denied such protection. Existing labor law must reflect the changing environment.

Health care workers, who understand that managed care has brought many changes to their industry, want to know that they will be protected deceitfully as the industry continues to transform itself. They especially want to work in an environment that allows them to deliver the best possible care to their patients. Unions will fight to ensure these protections.

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