

THE NURSING SHORTAGE AND ITS RELATIONSHIP TO PART TIME AND  
TEMPORARY EMPLOYMENT GROWTH: HOW SHOULD UNIONS RESPOND?

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ABSTRACT

Contingency employment -- comprised of part time, temporary, contract, and other categories -- has been growing rapidly in the 1980's. While employers have long used contingent workers to ride out economic downturns, today contingency employment is growing under robust economic conditions. This trend signals a more permanent restructuring of the labor market and prompts debate over why contingency is proliferating, why these workers are paid less than full timers, and to what extent contingent arrangements are voluntary. In response, unions have either restricted contingency growth, or organized and bargained for increased benefits for contingent workers.

The body of this thesis examines contingency among hospital registered nurses nationally, and locally in the Boston area, and looks at this trend in relationship to the current nursing shortage. I show that the nurse labor market is qualitatively different than other labor markets, particularly when it comes to staffing arrangements. In short, part time and temporary registered nurses have pay parity or better with their full time counterparts, and have more control and flexibility over the hours that they work.

My major hypothesis is that while nurse contingency appears to be voluntary, nurses' increasing contingency is actually a response to deteriorating job and hospital conditions -- which are brought about by hospital efforts to realize profits under new regulatory pressures. The contingency issue is heightened because this trend is exacerbating the nursing shortage. Contingency also threatens nurse's unions power as full time members go part time or per diem (and ostensibly have less commitment to the union), or leave the union to work as agency temporaries. While there are a variety of ways nurse's unions can respond, I argue that nurse's unions should: 1) set up a commission to revamp regulatory policies that structure nurses' jobs and the care they are able to give; 2) reduce the work week for full time nurses; and 3) offer temporary nurses' association union membership.

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## INTRODUCTION

Workplace staffing arrangements are changing dramatically. Both professionals and non-professionals -- who used to rely on full time and longer term employment are increasingly working at part time, temporary, and other kinds of contingent arrangements. While difficult to measure, by all estimates contingency has grown rapidly in the 1980's. Between 1980 and 1985 contingency employment<sup>1</sup> grew from eight million to 18 million -- to become 17 percent of the total U.S. labor force, according to data published in Businessweek magazine. When part time workers that are "voluntary" (a U.S. government characterization of workers who choose less than full time employment) are added to that 17 percent figure, the result is contingency status for one in every four U.S. workers in 1985.<sup>2</sup> Current debates rage over a number of issues including why contingency is proliferating given the fact that the U.S. economy is stable; why contingent workers are generally paid less and receive fewer benefits than their full time counterparts; and to what extent contingent arrangements are voluntary.

The first chapter of my thesis positions these current questions and debates within theoretical constructs. In chapter

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<sup>1</sup> By this estimate, contingent workers include leased employees, temporary workers, involuntary part timers, employees of subcontractors, and home-workers.

<sup>2</sup> Bennett Harrison, The Great U-Turn, forthcoming, p.42

two, I briefly consider how unions have historically reacted to less than full time employment growth, and how they are revamping traditional strategies to respond to current contingency surges -- that are more frequent, and of a different character than they were in the past. In chapter two, I also argue that context -- which includes worker preference, employer motivation, and the general health of the industry -- should be carefully considered before unions decide how to respond to contingency growth. For example, the forces fueling part time growth among airline reservationists may be qualitatively different than those prompting contingency among computer system analysts, i.e., airline management is using a part time, second tier workforce to cut labor costs, while system analysts may be choosing part time employment because part time pay is adequate.

These first two chapters lead up to the body of my research which focuses on understanding the nature of contingency in the registered nurse (RN) labor market and assesses how nurse unions might respond to these changing staff arrangements. More specifically, in chapter three I review national hospital industry and nursing labor market data, and I apply and consider the relevance of contingency theories outlined earlier. Next, I concentrate more closely on evaluating greater Boston's full time and contingency nursing market by analyzing local industry and labor market trends. And, finally, by interviewing nurses and nurse employers I consider in more depth issues that revolve around changes in staff arrangements. In my concluding remarks,

I make a series of recommendations for how Boston area nurse's unions could respond to contingency surges which may potentially undermine their membership base. In light of my argument that context is the most important variable in determining union response, and given that there is substantial regional differences in the nursing labor market, this detailed labor market approach is justified.

The following defines the two contingency employment groups that relate to the registered nurse labor market -- part time and temporary workers (both agency and per diem) -- and contrasts them to permanent, full time workers. In addition to part timers and temporaries, the contingency work force is composed of numerous other kinds of workers, including casual hires, contract workers, seasonal workers, and others.

#### **INVOLUNTARY PART TIME ON THE RISE**

According to the Bureau of Labor Statistics, the part time work force -- that employs the most numerous workers of the contingency categories -- is comprised of individuals working less than 35 hours. More specifically the government defines part timers as 1) unemployed workers seeking part time work, 2) "voluntary" part time workers, 3) employed part timers who are not at work the week the government surveys households (CPS survey), and 4) starting in 1986, "involuntary" part time workers -- that is workers looking for but unable to find full time employment. By BLS definitions, part time employment has

grown from 14 percent of the total workforce (10,642) in 1968 to 17.4 percent (18,615) in 1985.<sup>3</sup>

Many economists testify, however, that part time employment is under-estimated because "involuntary" part time work, which has been increasing rapidly in the 1980's, has not been reflected historically in the BLS part time category. And, economist Thomas Nardone further argues that even with the recent BLS addition of "involuntary" part time workers, part time employment is under-counted because this category does not measure workers who hold two jobs (two part time, or one full and one part time job) -- employment categories he believes are increasing.<sup>4</sup>

Economists who have reconfigured BLS estimates to better reflect the true nature of part time employment growth are alarmed at the increasing rate of "involuntary" part time employment which grew 60 percent between 1979 and 1985 -- from 3.5 to 5.6 million workers.<sup>5</sup> Involuntary part timers are one of the employment categories that economists wrangle over during debates over whether rising part time employment is driven by worker preference or employer demand.

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<sup>3</sup> James Rebitzer, "The Demand for Part-time Workers: Theory, Evidence, and Policy Implications," University of Texas at Austin, December 1987

<sup>4</sup> Thomas Nardone, "Part Time Workers: Who Are They?" Monthly Labor Review, February 1986, p. 18

<sup>5</sup> Virginia duRivage, Working at the Margins: Part-time and Temporary Workers in the U.S., 9 to 5, National Association of Working Women Report, September 1986, p. 94



In general, part time workers -- who in 1983 were close to 70 percent women -- are paid less than their full time counterparts. In 1983, they averaged \$5.48 an hour, considerably less than full time females at \$6.57 an hour, and full time males, who averaged \$9.74 an hour. Additionally, part time workers are less likely to have health insurance or receive pension benefits. In 1983, 21 percent of part timers had group health insurance in comparison to 72 percent of full time females, and 81 percent of full time males. And, while 46 and 57 percent of full time women and men received pension benefits, only 14 percent of part timers had access to this benefit. Finally, part timers are less likely to be unionized: 9 percent of part timers were unionized in 1983, in comparison to double that figure for full timers.<sup>6</sup>

#### **TEMPORARY EMPLOYMENT GROWTH SIGNALING FURTHER RE-STRUCTURING**

Temporary agency workers -- representing only one percent of total non-agricultural wage and salary workers in 1985 -- are the smallest of the contingency categories but the fastest growing. In fact, between 1982 and 1985, temporary employment almost doubled in size, accounting for three percent of total job growth during that period.<sup>7</sup> As in the case above, economists think temporary employment is under-estimated: the

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<sup>6</sup> Ibid., pps. 9,10

<sup>7</sup> Max Carey and Kim Hazelbaker, "Employment Growth in the Temporary Help Industry," Monthly Labor Review, April 1986

data reflects temporary workers employed by temporary help agencies, but does not include temporaries who firms hire directly.

There are four main categories of temporary workers: office and clerical is the largest, representing over fifty percent of all temporary workers; other categories include medical (1/10th of the total temp workforce), industrial (3/10ths), and professional temporaries.<sup>8</sup> In general, temporary workers receive a lower wage rate than their full time counterparts, although the cost to employers may be the same or greater than hiring full timers. In most markets, temporaries function as an expandable and expendable workforce -- in that temporary employment declines at the start of recessions, and recovers quickly at the beginning of expansions.

While the percentage of the workforce that temporary employment represents is small, this employment group is being carefully watched for a couple of reasons. Economists argue that rapid temporary growth is another sign of current employment restructuring, and further that there are indications that temporary help is becoming a more permanent function. Additionally, temporary agencies are fulfilling another employment niche in some markets (i.e., nursing and secretarial): Under shortage conditions agencies provide firms with workers for a premium.

Different theories attempt to explain why employment in part

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<sup>8</sup> Ibid.

time, temporary, and other contingency categories are growing given that the U.S. economy has been fairly stable during the last five years.

## CHAPTER ONE

### CONTRASTING THEORIES ON WHY CONTINGENCY IS GROWING

The various opinions and theories about why contingency is growing can be broadly classified under neoclassical and institutional paradigms. Various iterations of "dual market" theory constitute the institutional perspective, while the leading theories within the neoclassical traditions are "market clearing" and "compensating wage differential." Although different in context, these various theories address the following general questions: Why has there been an explosion in part-time, temporary, and contract employment over the last decade; Why are contingent workers generally paid less than full-time workers?; And, to what extent is part-time, temporary, and contract work voluntary?

After considering the leading theories from both the neoclassical and institutional traditions, I will review how different unions have responded to contingency growth, and explain why a strategic response is important to the labor movement's future viability. Then, I will narrow my focus to analyze whether the growing incidence of part time and temporary registered nurse employment fits into prevailing theories about contingency employment, and how nurse unions might respond to that growth.

## THE CONVENTIONAL VIEW OF CONTINGENCY

Neoclassical labor market theory asserts that the labor market operates like the commodities market. More specifically, this means that labor markets move towards an equilibrium level, where there exists a single wage rate, at which labor supply is equal to labor demand. Known commonly as "market clearing," this phenomenon characterizes the market for nurses (labor) or doritos (commodity) and is based on the logic of market competition. In terms of contingency, neoclassical economists argue that in the 1980's both workers and employers are benefiting from contingency arrangements, hence their taste for contingency is converging and equalizing (market clearing).

While management has long used contingent labor to ride out economic downturns, the new wrinkle is management's desire for a part time labor force when economic times are robust. The notion that full time workers are a management liability came about in the 1980's, after companies were forced to lay off significant numbers of blue and white collar workers during the recession.<sup>9</sup> Referring to changes brought about by international competition and technology innovation, Mark de Bernardo, from the U.S. Chamber of Commerce, said that work forces made up entirely of full-time employees "tend to handcuff the employer

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<sup>9</sup> Bureau of National Affairs, The Changing Workplace: New Directions in Staffing and Scheduling, a special report, 1986, p.3

in a time when there is a revolution in the workplace." <sup>10</sup>

"While the people who are terminated in the restructuring process have a tendency to see the process as capricious, the rationale of management is the creation of a more viable, productive, and lean organization based on economic necessity and increased job security," said Mitchell Fromstein, president of Manpower, a national temporary agency.<sup>11</sup>

Conventional economists argue that this new and increased employer demand for contingent workers has coincided with employee desire for scheduling flexibility: the influx of mothers into the labor force demanding flexible work schedules to accommodate family needs, more workers who are making the transition between different jobs, school and work, as well as those easing into retirement.

"The baby boomers have started this -- they (like employers) don't want to make a long term commitment," said James Walker, a consultant at Cresap, McCormick, and Paget, a large management consulting firm.<sup>12</sup>

Neoclassical economists also explain the contingency phenomenon by using the "law of one price" theory and "compensating wage differential theory" which both fall out of

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<sup>10</sup> Ibid, p.3

<sup>11</sup> 9 to 5 Report, p.1

<sup>12</sup> Bureau of National Affairs Special Report, p. 5

the market clearing/equilibrium principal.<sup>13</sup> The "one price" theory asserts that under competitive conditions, workers of the same quality (experience, education, skill, etc.) will tend towards equal wages throughout the labor market. For example, this theory would argue that technicians making \$6 an hour at Mass General Hospital will leave to work for \$7 an hour at Children's Hospital, all things being equal. And, the theory asserts that as more technicians flock to Children's Hospital, hourly wage rates will fall, while simultaneously wages at Mass General will increase in order to attract back the workers they lost. In short, according to the law of "one price," wage rates will be equalized in the hospital labor market through this process.

The "compensating wage differential" theory says that part-time wages will be lower than full-time wages only when part-timers are satisfied that they are receiving an equal non-monetary compensation for working less than 40 hours. For example, in a competitive market, part-time Delta Airline workers are willing to forego: full-time hourly wages, full-time benefits, and 40 hour weeks in order to work fewer hours because they desire increased leisure and more time to spend with their families.

A paper by Cornell economist Ronald Ehrenberg empirically tests the "compensating wage differential" theory, and generally agrees with neoclassical economists who argue that contingency

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<sup>13</sup> James Rebitzer, pps 2-14

growth is driven by worker preference.<sup>14</sup> Ehrenberg argues that studies showing that part-time workers are less costly than full time workers do not explain the contingency trend. Rather, he argues, to explain contingency growth economists must illustrate that the relative cost advantage of part-time employment has increased over time and that variations in the relative cost advantage parallel variation in part-time employment.

Ehrenberg's analysis (he uses March 1984 CPS data) shows that (1) inter-industry variations in part-time/full-time employment could be explained by relative cost variations across industries; and (2) that the relative cost of part-time workers influences both relative supply (vis a vis full timers) and relative demand. Ehrenberg asserts that when relative wage levels are considered, worker preference and other supply factors are a better explanation of why part time employment is increasing, although he admits that his model may not be entirely appropriate given the inclusion of involuntary part-time workers in the part-time category. And, pointing to the increase in "involuntary" part time employment, Ehrenberg concedes that some part time employment growth is employer driven.

In summary, most neoclassical theory asserts that contingent work arrangements in a competitive labor market are largely voluntary (worker preference or supply driven), and that non-

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<sup>14</sup> Ronald Ehrenberg et al., "Part Time Employment in the U.S., forthcoming in a Cornell Industry Relations conference volume, edited by Robert A. Hart



monetary benefits (flexibility, variation, time spent with family, etc.) compensate for the financial benefits lost by not working full-time. Neoclassical economists also argue that contingent workers are largely women, the young, and the old, because these groups place higher value on flexibility and shorter hours. <sup>15</sup>

### INSTITUTIONAL THEORIES

Economists from the institutionalist school have described the contingency phenomenon in various ways within the context of dual market theory. In brief, dual labor market theory, first asserted by Peter Doeringer and Michael Piore in 1971, states that two labor markets -- a primary and secondary labor market -- exist with qualitatively different rules governing market entry, upward mobility, and the relationship of earnings to age, experience, education, and skill.

In the primary labor market, the human capital nexus of education, experience, and skill places workers in the labor queue in a hierarchical and systematic fashion. Primary workers, often known as core workers, receive more pay and move upward within the firm (along internal labor markets) as their experience increases. Core workers usually work on a full-time basis, are rewarded for longevity by their firms, generally receive higher pay and more extensive benefits than secondary workers, and on average, increase their earnings to

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<sup>15</sup> James Rebitzer, p. 8

approximately the age of 50 when wages level off.

Unlike the primary market, the human capital nexus bears little relationship to who gets jobs within the secondary market, and there is no systematic vehicle for upward mobility within or out of the secondary market (an absence of an internal labor market). Dual market theorists argue that there is a more elastic demand for periphery workers, and that therefore their wages and benefits are lower than those in the core. This market is characterized by a growing number of contingent workers, and is largely composed of women, minorities, the young, and the old. Given their low wages and lack of mobility, periphery workers frequently turn over, and trade off between working at dead-end/low paying jobs, going on welfare, hustling jobs on the black market, and dropping out of the labor market all together.

Internal labor markets are important to employers as well as workers, particularly employers that are expanding. As production increases, workers move up the company's pipeline to meet demand, and new workers are hired. Internal markets, which reward workers for experience, skill, and education, are efficient when compared to the cost of recruiting, hiring, and training new workers to meet increased demand.

Temple University economist Eileen Appelbaum believes, however, that internal labor markets are becoming less cost efficient, and therefore less important because companies in the

1980's are "poised for contraction" rather than expansion.<sup>16</sup> Companies today are down-sizing for numerous reasons, including anticipation of shrinking market share or loss due to domestic and international restructuring; international competition; and reduced worker input because of labor-saving technology innovations. Varying by industry, the pressures to down-size include: de-regulation in the transportation industry; changes in federal regulations and payment in the health care industry; foreign penetration of U.S. markets in the automobile industry, among others.

The main reason contingency is on the rise is that employers have continued to use contingent workers to meet increased and sporadic demand long after the 1981 - 1982 recession has subsided, argues Appelbaum. While historically contingent workers have been used to ride out economic fluctuations, allowing employers to retrench when there is a business downturn, the trend has not reversed itself in the healthier climate of the mid 1980's.

While contingent workers are overwhelmingly female, increased female labor force participation has not caused the recent in-voluntary contingency surge. A study by Deutermann and Brown shows that since 1960 there has been a steady decline in family/home responsibilities as the reason women cite for

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<sup>16</sup> Heidi Hartmann et al., Computer Chips and Paper Clips, National Academy of Science Press, 1986, p. 271

working part-time.<sup>17</sup> And a 1980 survey by Presser and Baldwin found that 23.5 percent of part-time mothers with children under five years old would work more hours if child care were available.<sup>18</sup> While I would characterize these mothers as involuntarily part time, the Bureau of Labor Statistics does not. Therefore, they are not included in the growing involuntary part time ranks.

University of Texas economist Jim Rebitzer also believes that employer demand is the main force driving contingency growth. Rebitzer's EWCLF (efficiency wage-contingent labor force) theory of demand for part-time work asserts that: 1) part-timers' low wages reflect an industrial relations strategy rather than preferences of part-timers (disputes compensating wage theory); and 2) that the higher the percentage part-time in a given industry, the lower the full time wages and benefits within the industry. Considering this second point Rebitzer shows, by comparing the same job in different industries, that sectors with high part-time frequency are characterized both by relatively large numbers of full time contingent workers, and by primary workers who compensate for a reduced likelihood of

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<sup>17</sup> Ibid., p. 283

<sup>18</sup> Harriet Presser and Wendy Baldwin, "Childcare as a Constraint on Employment," American Journal of Sociology March 1980, p. 1202-1213

layoff with lower wages, all else being equal.<sup>19</sup>

Rebitzer's model refutes many standard labor market theories. He argues that the "law of one price" does not hold because firms hire some workers in high wage, core jobs and others in lower wage, contingent jobs, even when workers are the same quality and doing the same job. Also, says Rebitzer, labor markets will not clear. When demand for primary jobs exceeds supply, firms will not lower primary wages and hire more core workers because lowered wages reduce the incentive for core employees to work hard and exhibit firm loyalty. Conversely, when primary jobs are scarce, involuntary part time employment grows, and employers discriminate in allocating workers into primary jobs. Workers with high quit propensities -- women with children, young, and older workers -- are the first workers employers exclude from primary jobs.

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<sup>19</sup> James Rebitzer, p.11

## CHAPTER TWO

### UNION RESPONSES TO CONTINGENCY

Unions have reacted to this contingency explosion -- characterized by MIT professor Tom Kochan as the "most significant labor market development of the 1980's" -- in basically two different ways. They have either restricted contingency growth, or organized and bargained for increased benefits for contingent workers. Historically, the labor movement attempted to limit the growth of part time, temporary, and contract workers by staunchly opposing changes in hours and terms of employment. More recently, however, some unions have gone to the bargaining table to protect the legal rights, employment security, and living standards of contingent workers. The Service Employees International Union (SEIU) leadership's advice to its locals illustrates the contradiction that exists within the labor movement around contingency, "Ban 'em, limit 'em, or organize 'em."

It is the context that primarily determines how unions respond to a surge in contingency employment, and there appears to be three broad, often intertwined, contexts that are currently shaping union response. In brief, the context parameters are defined by: 1) employers' who want to substitute contingent for full time, often unionized workers (dual market); 2) workers' desire for contingent arrangements, a voluntary

condition (compensating wage differential); and/or 3) a legitimate fiscal crisis -- such as a budget squeeze in the public sector or industrial restructuring in the private sector -- where the union faces the threat of layoffs. The overall challenge for the union movement is to protect the bargaining units of existing full time members, while simultaneously enticing voluntary contingent workers to become members by targeting services and benefits to meet their needs, and working to prevent increases in non-voluntary contingency.

Union leadership on this issue is particularly crucial as the membership of the labor movement continues to decline -- from approximately 35 percent in the mid 1950's to 17 percent in 1987. In addition to this eroding membership and power base, union members have recently experienced unprecedented wage and benefit cuts. In fact, between 1980 and 1984, 40 percent of union members under major collective bargaining agreements experienced wage losses.<sup>20</sup> Unfortunately, this trend has not recently abated. In the first half of 1987, SEIU reported that 37 percent of union contracts included language about wage freezes or pay cuts, and 12 percent of contracts institutionalized a two-tier wage scale.<sup>21</sup>

A large portion of the labor movement's decline is attributed

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<sup>20</sup> Thomas Kochan and Joel Cutcher-Gershenfeld, "Institutionalizing and Diffusing Innovation in Industrial Relations," MIT Sloan School Working Paper (WP 1928-87), September, 1987, introduction

<sup>21</sup> Service Employees International Union "Work and Family" conference proceedings

to our country's transformation from a manufacturing (heavily unionized) to a service-based (limited union membership) economy and the resultant re-structuring of the labor force. Other factors include: increased management opposition to unions; declining public and government support for the labor movement; de-regulation of traditionally unionized industries, prompting fierce competition and pressures to cut wages and employment; global wage and import competition; and unions inability to organize the traditionally unorganized.

Whatever the reason for this dramatic membership decline, it is clear that part of the way the U.S. labor movement will remain viable is to unionize growth industries that are virtually or nearly unorganized, namely the hotel and restaurant, retail, business services, and health care industries. It is in these growth sectors that the frequency of contingency employment has recently and rapidly been increasing, particularly in retail trade, personnel services, nursing homes, janitorial services, and hospitals.<sup>22</sup>

Unions have an important role to play: part timers rate of unionization is approximately one third of full timers, and other categories of contingent workers are virtually unorganized. In 1985, 7.3 percent of the part time labor force (1.27 million workers) belonged to a union, in comparison to

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<sup>22</sup> Thomas Nardone, p 13



20.4 percent of full time workers.<sup>23</sup> In all, according to the Monthly Labor Review, about one in 14 union members works a part time schedule. Unions have only very recently considered initiating temporary and contract worker membership drives.<sup>24</sup> Due to their ever-changing employment location and other reasons, this labor force is particularly difficult to organize.

To date, public and service sector unions with high proportions of women members have organized the greatest number of part time workers. The United Food and Commercial Workers Union (UFCW), the Service Employees International Union (SEIU), District 925/SEIU, District 65 of the United Auto Workers Union, and the American Federation of State, County and Municipal Employees (AFSCME), are unions that have targeted their efforts towards contingent workers.

These unions have pioneered in: organizing part timers and long term temporary employees; providing permanent part time positions with decent wages; transforming temporary jobs into full time positions; and developing job sharing programs. These efforts will be discussed below. Some have also been able to influence or restrict how employers use contingent workers, i.e., when they can be hired, their working conditions, and the

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<sup>23</sup> Eileen Appelbaum and Judith Gregory, "Union Approaches to Contingent Work Arrangements," March 1988, forthcoming

<sup>24</sup> Ibid., p. 14

effect contingent employment has on the core workforce.<sup>25</sup> These unions, and increasingly their more traditional counterparts, have recognized that in many instances restricting the growing number of part time and other contingent workers from the bargaining unit doesn't make sense. Instead, they are experimenting with associate membership status and other non-traditional accords for workers who don't want, or are unable to establish a traditional collective bargaining relationship.

Contract language covering contingency workers differs dramatically from union to union and industry to industry, according to a report prepared by Cornell University's Industrial and Labor Relations (ILR) school. The report, based on a survey of contracts housed in the ILR Documentation Center, found that the kind of contingency workers covered differed remarkably, and clauses related to benefits, hours, job security, and wages were varied.<sup>26</sup>

In general, when unions are bargaining for contingent workers they attempt to:

- \* Achieve wage parity between full and part time workers;
- \* Include part time and temporary workers in the bargaining unit;
- \* Transition temporary or part time jobs into full time positions;

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<sup>25</sup> For a more detailed review of specific union strategies and contexts see, "Union Approaches to Contingent Work Arrangements," Eileen Appelbaum, Temple University and Judith Gregory, University of California at San Diego, March 1988, forthcoming

<sup>26</sup> Kate Bronfenbrenner, "Survey of Contract Language Covering Contingency Workers," New York School of Industrial and Labor Relations, Cornell University

- \* Require pro-rated or full benefit coverage for part timers;
- \* Guarantee minimum hours of work per week; and
- \* Require the employer to pay overtime compensation, conduct job evaluations, and set up advancement ladders for part timers.

Union effort to improve the status of voluntary contingent workers is a sign that the labor movement is starting to recognize that members' needs have changed, and that some workers, particularly mothers, want less than full time work. For example, the Coalition of Labor Union Women's (CLUW) platform calls for a broader occupational range of part time jobs, increased benefits and job security for less than full time workers, and inclusion of part timers in the bargaining unit. SEIU has bargained for contracts that require employers to conduct job evaluations, and provide pay raises and job advancement for part timers. SEIU has also worked to provide contract provisions that enable members (in particular parents) to share jobs or reduce their hours of work, returning to full time status at a later period. <sup>27</sup>

When unions are bargaining to prevent contingency, contract provisions include language that:

- \* Restricts use of temporaries and part timers;
- \* Requires the company to report their use of contingent workers on a periodic basis;
- \* Allows the union to evaluate the use of less than full time employees;
- \* Gives priority to full time workers for overtime hours;
- \* Protects against displacement of full time workers by part timers or temporaries; and
- \* In general, protects wages, benefits, and seniority of full time workers from erosion by part timers.

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<sup>27</sup> Eileen Appelbaum and Judith Gregory, p.20

Some examples of successful union opposition to involuntary contingency or worker marginalization include the following. Local 20 of the Office of Professional Employees International Union (OPEIU) stopped Blue Cross from substituting temporary workers for full time workers who Blue Cross was laying off. The 1986 OPEIU/Blue Cross contract restricted the company from hiring outside agency temps, (who at the time were 10 percent of their work force and growing) and required them to hire back ex-Blue Cross employees for temporary and full time positions.<sup>28</sup> And, SEIU local 790 successfully bargained for full time status for 200 "temporary" city employees -- half of these "temps" had worked for the city for more than two and half years on full and part time schedules without the pay and benefit levels commiserate to their permanent counterparts.<sup>29</sup>

In light of the fact that the forces driving contingency vary among industries, occupations, and firms it is important for individual unions to spend the time and resources to understand the particular context under which contingency is increasing. As a rule of thumb, unions should be opposing employers' marginalization of workers and the growth of involuntary part time employment, while working to provide voluntary contingent workers with pay and benefit parity, access to grievance procedures, job protection, advancement ladders, and other benefits. Some unions also try to work with management when

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<sup>28</sup> 9 to 5 Report, p. 37

<sup>29</sup> Ibid., p. 14

there is a legitimate fiscal or budgetary crisis to save jobs by making the transition from full to less than full time employment for a discrete period of time. This last context provides a lot of uncertainty in terms of what constitutes a legitimate crisis, who's got control over the full to part time transition process, among other issues. While I recognize that this last context is important, I am not discussing it in this paper because it is not a context that presently applies to nurses.

One of the reason I decided to further explore general contingency theories by applying them to one occupation and one industry is because, as I said above, I think context is the most important variable for unions to consider. More specifically, I choose to focus on hospital registered nurses because I think the nurse labor market is qualitatively different than other labor markets, particularly when it comes to contingency. In addition to exploring these labor market differences, I was interested in applying prevailing contingency theories to a market experiencing a supply shortage, and in understanding how the fact that nursing is predominantly female influences potential labor market outcomes. These tensions and issues framed my overriding question which is, how might nurse's unions respond to the contingency phenomenon?

Before a discussion of registered nurse labor market characteristics, I will analyze the current hospital industry market. This analysis will help the reader understand how both

the changing hospital regulatory environment and increased industry competition, plus the growth of health care temporary agencies is affecting hospital nursing personnel -- and more specifically, how these forces have fueled contingency growth.

## CHAPTER THREE

### HOSPITAL NURSING A NATIONAL PERSPECTIVE

#### THE U.S. HOSPITAL INDUSTRY

In 1987, the health care industry employed eight million workers -- after government and retail the third largest number of workers in any given industry.<sup>30</sup> And, until very recently, employment expansion in health care has been dramatic. Between 1960 and 1984, health care employment growth averaged 5.9 percent annually -- nearly three times the rate of employment growth in the private sector as a whole.<sup>31</sup>

Paralleling its employment growth, health services have increasingly affected the U.S. economy. In 1984, 10.6 percent of U.S. GNP was spent on health services, up from 4.4 percent in 1950 (in 1984 dollars).<sup>32</sup> This growth has been fueled by a number of factors, including increases in private health insurance coverage, and the introduction of federally funded Medicare and Medicaid programs. To illustrate that change, government and private insurers paid 50 percent of medical care cost in 1966, but by 1984, these institutions were paying a full

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<sup>30</sup> Eli Ginsberg, "Nurses for the Future," American Journal of Nursing, December 1988

<sup>31</sup> Ibid., p. 24

<sup>32</sup> Ibid., p. 19

72 percent of total medical cost.<sup>33</sup>

Within the health services sector, hospitals hire the majority of workers. In 1984, 57 percent of health care employees workers in hospitals. However, employment concentration is changing, and current growth is in HMO's (health maintenance organizations), and other out-patient services.

#### DRG's Affect Employment Growth

After a quarter century of steady growth, employment in health services started to level off in the mid 1980s, most visibly in the hospital sector. The most important variable influencing this employment slow down has been government regulations in the form of hospital cost containment measures, namely the diagnosis reimbursement system (DRG's). Factors that contributed to health care belt tightening and resultant DRG regulations were the U.S. recession, rising inflation, the growing cost of employee benefits, and state fiscal crises.

Announced in 1983, and phased in over a three year period starting in 1984, DRG's have dramatically affected employment levels, staffing patterns, and the hospital environment. DRGs control hospital costs by linking the medicare payments hospitals receive for in-patient services to pre-determined rates in 467 diagnosis-related groups. If a given hospital

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<sup>33</sup> Ibid., p. 19



spends less on a patient than the DRG rate allows, they can retain the savings, but if costs exceed the DRG rate, the institution must absorb the expense. Prior to the advent of DRG's, hospitals were generally reimbursed for all Medicare inpatient service costs incurred.

Starting in 1983, in anticipation of DRG implementation, hospitals began reducing admissions of less acutely ill patients and shortened hospital stays. Between 1983 and 1984, total admissions fell a sharp 4 percent nationally; length of average patient stay decreased 5.1 percent; and length of stay for medicare patients (DRG reimbursable) plummeted 20 percent. Hospital cost containment efforts were immediately apparent. In 1983, hospital expenditures were 10.2 percent; in 1984 they fell to 4.5 percent.<sup>34</sup>

More recent and inclusive figures show that between 1981 and 1986, average hospital occupancy fell from 75.9 percent to 63.4 percent nationally; and inpatient hospital days decreased by 50 million. Also, between 1981 and 1986, 414 hospitals closed resulting in 56,628 fewer beds.<sup>35</sup>

Hospitals response to DRG regulations can be characterized in three different categories: "beating the system strategies,"

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<sup>34</sup> Eileen Appelbaum and Cherlyn Grandrose, "Hospital Employment Under Revised Medicare Payment System," Monthly Labor Review, August 1986, p. 38

<sup>35</sup> John Igelhart "Problems Facing the Nursing Profession," New England Journal of Medicine, September 3, 1987, p. 647

marketing and business strategies, and labor force strategies.<sup>36</sup>

"Beating the system strategies include procedures that identify diagnosis combinations which maximize payment; discharging patients as soon as possible; and encouraging more use of outpatient services. Marketing strategies attempt to increase hospital jurisdiction, such as alcohol treatment and physical rehabilitation. Marketing strategies also target younger patients in higher socio-economic groups that are less likely to have serious, long term complications. In addition, general business strategies have emphasized joint ventures, mergers, specialization, and the introduction of new programs and services to increase profits and mitigate regulatory impact on revenues.

Finally, labor force strategies -- particularly important because they are the focus of this paper, and because labor costs average 50 percent of hospital operating budgets -- consist of staff cuts, hiring freezes, increased part-time usage, on-call staff, contracting out of services, and increased use of skilled personnel who can perform a wide variety of services. As at least a partial result of labor force strategies hospital employment decreased overall by 73,000 workers in 1984, and 37,000 workers in 1985.<sup>37</sup>

But despite hospital industry fears regarding DRG regulations, hospital revenues still grew seven percent between

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<sup>36</sup> Eileen Appelbaum and Cherlyn Grandrose, p. 38

<sup>37</sup> American Journal of Nursing, p. 38

1984 and 1985, according to the American Hospital Association (AHA). This may be in part because expenses -- due to wages and benefits -- were constricted, only growing four percent between 1984 and 1985.<sup>38</sup>

#### LABOR MARKET CHARACTERISTICS OF RNS

Registered nurses, the largest group of health professionals in the U.S., is the ninth largest occupation for women and one of the highest paid predominantly female profession.<sup>39</sup> RN employment, approximated at 2.1 million in 1986, doubled over the last thirty years and grew by 49 percent in the last 10 years. As a result, RN - patient ratios have gone up: from 50 RNs per 100 patients in 1972, to 91 per 100 patients in 1986.<sup>40</sup>

Although hospitals pared down their employment ranks in response to DRG regulations and market conditions -- employing 133,376 fewer full time equivalent hospital workers in 1986 than 1983 -- RN hospital employment actually increased by 37,500 during the same three year period.<sup>41</sup> And, a recent AHA survey found that 46 percent of all hospitals reported an increase in

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<sup>38</sup> Louise Kaplan, "Desperately Seeking Nurses: RNs Don't Care for Hospital Practices," Dollars & Sense, March 1988, p. 9

<sup>39</sup> Heidi Hartmann, pps. 52, 53

<sup>40</sup> Linda Aiken, "The Nursing Shortage: Myth or Reality" New England Journal of Medicine, September 10, 1987, p. 641

<sup>41</sup> Ibid., p. 642

the number of RNs employed from 1986 and 1987. <sup>42</sup> Two thirds of all RNs presently work in hospitals, and within hospitals, RNs comprise approximately 58 percent of total nursing staff. In contrast, RNs only accounted for 33 percent of hospital nursing staff in 1968, a period when hospitals employed more licensed practical nurses (LPNs), an occupation one step down on the nursing hierarchy.<sup>43</sup>

LPNs, who receive one year training, are not allowed to perform RN tasks including dispensing medication and administering intravenous feeding. Hospital policies also restrict LPNs from many patient assessment responsibilities, and from supervisory positions. And finally, on the bottom tier of the nursing hierarchy, are nurses aides -- semi-skilled workers who perform routine tasks such as changing beds and delivering meals. LPNs are gradually being phased out of the hospital setting for a variety of reasons, including the following: 1) pay -- the 80 percent wage differential between RNs and LPNs discourages LPN employment; hospitals can substitute two RNs for 3 LPNs and save money; (2) marketing strategies -- hospitals like to publicize the fact that they have a fully professional nursing staff; and (3) increasing patient acuity that, employers say, requires more RN expertise. Consequently, LPN employment

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<sup>42</sup> American Hospital Association, "The 1987 Hospital Nursing Personnel Survey," executive summary

<sup>43</sup> Linda Aiken, p.642

has been growing less rapidly than RN employment.<sup>44</sup>

In terms of racial composition, RNs are 90 percent white; LPNs are 80 percent white; and nurses aides are more racially mixed than either of these groups.<sup>45</sup> And, despite popular news accounts of males entering the nursing profession, RNs are still 97 percent female.

Nursing also has one of the highest labor force participation rates among workers in any predominantly female occupation -- almost 80 percent of RNs who have current licenses are employed either full-time or part-time. Little is known about the nurses who do not renew their licenses, and there are conflicting reports on the percentage of nurses who are employed in other occupations, or are looking for a job outside of nursing -- studies approximate anywhere from six to 20 percent of former nurses are no longer licensed.<sup>46</sup>

Nursing demand is expected to grow dramatically over the next decade as the U.S. population grows older and demands more health care services. The Bureau of Labor Statistics (BLS) predicts that between 1984 and 1995, the demand for RNs will be second only to the demand for cashiers. And, on this BLS list which projects employer demand, nurses aides and orderlies rank number seven. <sup>47</sup>

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<sup>44</sup> Louise Kaplan, p.9

<sup>45</sup> Heidi Hartmann, p. 53

<sup>46</sup> Linda Aiken, p. 643

<sup>47</sup> Bennett Harrison p. 80

## UNIONS AND THE HOSPITAL INDUSTRY

The nursing profession was virtually un-organized until the 1960's. Part of the reason is that the American Nurses Association -- who currently represents three fifths of the unionized nurses -- did not receive certification recognition from the National Labor Relations Board until 1949. Starting in the mid 1960's, however, there were numerous membership drives, and as a result the number of nurses under union contract rose from 16,850 in 1966 to 85,000 in 1976.<sup>48</sup> During that same period, union membership in the health care industry as a whole rose from six to 20 percent. In addition to the American Nurses Association who has state affiliates, the following unions also represent nurses: SEIU, District 1199 of the National Union of Hospital and Health Care Employees, Communication Workers of America (CWA), and AFSCME.

Similar to national trends, union membership in health care has fallen off in the 1980's -- from 23 percent in 1980 to 18 percent in 1985. Factors that have contributed to union membership decline include: hospital administrators efforts to fight unions, regulatory pressures that have prompted hospitals to cut labor costs, and perhaps an expanding employee base. Between 1981 and 1985 union members within the health care industry, like their national counterparts, have been forced to

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<sup>48</sup> Louise Kaplan, Brandeis University, unpublished paper

make wage concessions.<sup>49</sup> And, nurses have also had to withstand wage and benefit reduction pressures. For example, in 1984 and 1985 when DRG regulations were first implemented, the Mass Nurses Association worked to defeat an employer initiative to create a two-tier benefit package. This package would have offered reduced benefits to new hires.<sup>50</sup>

The challenge that nursing unions faced in the late 1970's and early 1980's was making sure that non-staff nurses i.e., temporaries and per diems, as well as part timers did not undermine full time wages and working conditions. For example, SEIU local 535 negotiated a contract with a California medical center that required employers to give full and part time staff priority for over time shifts before hiring agency nurses to fill staffing gaps. Another SEIU contract restricted per diem hiring by requiring the employer to offer per diems accrued benefits if they gave them full staff status.<sup>51</sup> And, in Minneapolis - St. Paul, registered nurses went on strike in 1984 over the lack of full time work. Whereas in 1977, 70 percent of RNs in that area worked full time, the ratio had fallen to only 30 percent when the nurses voted their dissatisfaction by walking off their jobs.<sup>52</sup>

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<sup>49</sup> AHA 1987 Survey, executive summary

<sup>50</sup> Louise Kaplan, unpublished

<sup>51</sup> Bureau of National Affairs, p. 103

<sup>52</sup> Bennett Harrison, p. 51

## THE CURRENT RN SHORTAGE DEVELOPED FAST AND FURIOUSLY

Historically, the hospital industry has measured nursing shortages by calculating the number of vacant, budgeted full-time equivalent positions. This employment gauge is somewhat problematic as the figures reflect budget constraints, hospital hiring freezes, regulatory pressures, and local wage rates -- not exactly a reflection of the need for bedside nurses. Vacancy rates have varied dramatically over the last few years -- from a 1986 high of 13.6 percent to an all time low of 3.7 percent in 1984 -- and have been higher for full time, as opposed to part time RNs. In 1986, the average hospital surveyed by the AHA reported a full to part time vacancy ratio of 10.9 to 5.3 percent, respectively. <sup>53</sup>

Nursing, however, has long been characterized by roller coaster vacancy rates: the vacancy rate in 1965 was over 20 percent; it dipped in the 70's to less than 10 percent; and shot up again in 1979 to about 14 percent. <sup>54</sup> The recent shortage has hit the news, in part, because it came fast and furiously -- from 1985 to 1986 the national vacancy rate more than doubled from 6.5 to 13.6 percent -- and in part because nursing school enrollment is currently declining so rapidly.

In terms of the contingency theory summarized earlier, RN part timers function differently than part timers in other labor

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<sup>53</sup> AHA, 1986 Survey, executive summary

<sup>54</sup> Linda Aiken, p. 643



markets in that part time nurses almost always have pay parity with full timers, and they generally receive pro-rated benefits. The following correlation matrix that incorporates national data from 1978, 1982, and 1985 illustrates how little variance there is between part time and full time nurses hourly wage rates.

And although wage rates for full and part timers have responded to shortage conditions, the wage response has lagged more than in other labor markets largely because nursing is a captured or closed market. Consider the following chronology. While, the introduction of Medicaid and Medicare programs in the 1960's increased the supply and wages of RNs, rate setting and cost containment measures in the 1970's dampened salary increases and contributed to the 1979 shortage. In response to this shortage in the late 1970's, wages rose annually an average of 13 percent in 1980 and 1981. But between 1982 and 1986, as DRGs were getting phased in, RNs received only modest wage increases. And, regardless of all the publicity the recent shortage has received, RN salaries only rose four percent in 1986: from an hourly average of \$12.17 in 1985 to \$12.70 an hour a year later.<sup>55</sup>

These slow wage responses are consistent with responses in oligopolistic markets i.e., there are a discrete number of employers, few employment options outside of health care, and until recently, not much wage competition between employers. Recently, however, nurse salaries have been rising more rapidly.

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<sup>55</sup> Linda Aiken, p. 643

Number of observations: 64

Series	Mean	S.D.	Maximum	Minimum
WFT	9.4320312	2.3876077	15.520000	5.8500000
WPT	9.5525000	2.4673686	15.810000	5.9200000

	Covariance	Correlation
WFT, WFT	5.6115974	1.0000000
WFT, WPT	5.7746418	0.9957893
WPT, WPT	5.9927843	1.0000000

Bureau of Labor Statistics Hospital Industry Wage Survey  
for full and part time registered nurses in 21 SMSAs  
during 1978, 1981, and 1985

In part, because this sluggish labor market is finally responding to the RN shortage, which is a reflection on nurses' increasing dissatisfaction with their jobs, and in part, I think, because nursing temporary agencies are currently undermining what has long been a captured market. This hypothesis will be further explored in the chapter on RN employers.

#### DEBATE OVER SHORTAGE FORCES

"Not only is this the first time a nursing shortage has cut across all categories of nurses and all regions of the country, but it is occurring despite the fact that demand for inpatient hospital care is declining,"

Connie Curran, VP, American Hospital Association. <sup>56</sup>

One of the biggest debates about the current RN shortage is over whether the phenomenon is supply or demand driven.

The supply-siders say that a combination of decreasing nursing school enrollment; changing population trends; and other career options for women have decreased the number of workers entering the profession, and have forced existing RNs to leave. Although almost nothing has been written on this subject, another reason the supply of full time RNs may be constricted is increased incidence of part-time and temporary agency employment.

In terms of the supply side variables, nursing school

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<sup>56</sup> John Ingelhart, p. 647

enrollment has decreased about 20 percent since 1983, and the number of new nurses graduating annually is predicted to fall from a high of 82,700 in 1985, to 68,700 or lower by 1995. In addition to declines in the number of 18 - 21 year olds, a recent survey found that female college students were 50 percent less likely to pursue a nursing career than in 1974. <sup>57</sup>

While starting salaries of nurses are competitive with other college graduate starting salaries, pay parity soon erodes. The average maximum salary for a nurse is only \$7,000 higher than nurses average starting salary which discourages people who plan to work continuously in the labor force.<sup>58</sup> This absence of wage increases over time is one example of how nursing markets do not conform to standard human capital theory which says that workers advance by internal labor markets and get paid for experience.

RN labor markets also largely fail to conform to another tenor of human capital theory: that workers are paid for educational achievement, and specialization. Approximately one third of all employed RNs have baccalaureate degrees, and the balance have two year associate degrees or three year hospital degrees. Various studies have shown, however, that RN educational levels do not determine pay or rank at the non-managerial level. In fact, there was only a .78 hourly wage difference -- or \$1,400 a year -- between BSN and associate

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<sup>57</sup> Linda Aiken, p. 644

<sup>58</sup> Ibid., p. 644

degree nurses in 1984.<sup>59</sup> Although in order for nurses to move into managerial positions, they generally must have a bachelor's degree. Nurses are also paid almost identically whether they are a general floor nurse (medical/surgery) or have an expertise in labor and delivery, emergency, or another area.

And, finally part time and temporary employment has been growing at the expense of full time employment. In 1986, 27 percent of the total pool of nurses worked part-time, an estimated 500,000 nurses, and in hospitals, the percentage of part-time nurses is higher. While data clearly shows that temporary employment has been increasingly recently, more importantly in terms of trends analysis, it appears that temporary employment is increasing faster than it did during the 1979 shortage. Of the hospitals in the AHA survey reporting a severe shortage in 1987, temporary agency staff were used 59 percent of the time to fill vacant FTE positions. The mean number of vacant shifts filled by agency RNs was 10.8 during the week of April 20, 1987, an increase of 2.6 shifts, or 31 percent, since December 1986.<sup>60</sup>

Those who believe that the nursing shortage is demand-driven point to the following variables: increased patient acuity under DRGs that warrants higher RN - patient ratios; increased hospital use of RNs to perform LPN, medical secretary and other

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<sup>59</sup> Charles Link, "Nurses for the Future," American Journal of Nursing, p. 1622

<sup>60</sup> 1986 AHA Survey, executive summary

responsibilities; hospital desire to have full RN staffs for marketing reasons, and changing budget constraints in hospitals.

Nurses report that patient acuity has increased as less acute patients leave the hospital for out-patient care. In 1986, 81 percent of RNs randomly surveyed by the AHA said that patient acuity had increased in the proceeding year.<sup>61</sup> This heightened acuity magnifies both the responsibility and the stress level for nurses, despite increases in RN - patient ratios, while at the same time reducing job satisfaction. Nurses' are finding their jobs less fulfilling than they did in the past because they no longer have the option to help patients fully recover: to realize a profit under DRG regulations, hospitals move patients out as soon as possible after surgery rather than allowing them to recuperate in the hospital.

Also under this system, RNs have substantially more paperwork because DRG regulations require that each nursing hour be justified for billing purposes. In addition, more sophisticated technology requires RNs to be less involved in actual patient care and more involved in machine tending. Others think that RNs have less support in their work places than they did in the past as LPNs get phased out and nurses perform a wider range of functions.

"Registered nurses are versatile employees...in that they can provide LPN and nurses aides services, and they can also perform a wide range of other functions, including those assigned to...secretarial and clerical personnel, laboratory technicians, pharmacists, physical therapists, and

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<sup>61</sup> 1986 AHA Survey, executive summary

social workers. Nurses substitute for physicians under some circumstances, and commonly assume hospital management roles after regular work hours. Thus, when nurses' relative wages are low as compared with other workers, it is advantageous for hospitals to employ them in greater numbers and in lieu of other kinds of workers,"

Linda Aiken, R.N., Ph.D.<sup>62</sup>

Aiken goes on to say that even if nurses wage are 20 to 30 percent higher than LPNs or medical secretaries, employers may use them because RNs are so versatile, and because they require little supervision.

Deteriorating job and workplace conditions are presently compounded by the nursing shortage and a corollary of that shortage: changing staffing arrangements. Staff nurses report that they are asked more frequently to work over time, and that they more regularly work on under-staffed units.<sup>63</sup>

Also, as more nurses work in part-time and temporary positions, full-time nurses' job responsibilities increase, further attributing to deteriorating job conditions. Depending upon the hospital, temporary nurses are not allowed to dispense medication, administer intravenous feeding, and assess patient condition. In most places temporary nurses are also not allowed to be "in charge" of a unit -- assigning patients, checking that everything is running smoothly, and making decisions in the event there is a crisis.<sup>64</sup>

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<sup>62</sup> Linda Aiken, p. 642

<sup>63</sup> Priscilla Scherer, American Journal of Nursing, October 1987, pps 1285-1290

<sup>64</sup> Compilation of Boston area interviews

"Temporary nurses basically work under my license, and I have to check up on them and make sure they are doing a good job," said a RN at Leahy Clinic.

In addition to government regulations, the hospital industry and hospital labor markets are being restructured by industry competition -- multinational corporations, for-profit companies, and insurance agencies have changed health care's long term non-profit character. As a result, hospitals have hired advertizing and direct mail companies to target desired patient populations and to distinguish their services and reputation in the marketplace. Part of hospitals' current marketing campaigns stress full-RN nursing staffs in order to attract more affluent patient populations.

In summary, while I think that the current nursing shortage is a result of interacting supply and demand factors, I believe that the shortage is initiated on the demand side -- more specifically it is driven by hospital employer pressures to realize profit margins under DRG regulations. In short, job and hospital conditions are deteriorating -- there is increased patient acuity, fewer RN support staff, additional paperwork, and less time to devote to helping patients recovery, which has long been one of the most satisfying things nurses do. These factors fuel shortage conditions by prompting some nurses to cut back on full time hours to reduce stress, others to leave the profession, and makes potential nurses think twice about entering nursing in the first place.

The following chapters on nursing in the greater Boston labor



market will explore the two sides to this current RN shortage debate in more detail. My interviews with nurses and employers will also give additional insight to issues that relate to increasing contingent arrangements, changing hospital environments, staff and temporary nurse relationships, and other dynamics.

## CHAPTER FOUR

### AN IN-DEPTH LOOK AT BOSTON AREA RN MARKETS

#### MASSACHUSETTS HOSPITAL INDUSTRY FOLLOWS NATIONAL TRENDS

While the following interviews with nurses and employers were all conducted in the greater Boston area, there was not enough available data to do a fuller analysis of area market conditions. Consequently, my analysis of the current hospital and RN markets uses state employment data and Massachusetts-wide hospital surveys. Given that the Boston area is Massachusetts medical mecca, I think that use of Massachusetts rather than local data is acceptable.

According to 1984 Massachusetts Division of Employment Security figures, health care employs 11 percent of the Boston area workforce, considerably higher than the 9 percent the industry employs statewide. Paralleling national trends, the absolute number of Massachusetts health service workers has increased steadily over the last two decades, however, starting in 1982, employment growth started to slow down and employment increases have recently hovered around 2 percent annually. This slow down is due to a net decline in hospital employment that comprises over fifty-seven percent of Massachusetts health services employment. In fact, between 1982 and 1984, the hospital sector experienced net job loss through attrition and layoffs of 2,600 workers, and during 1985 and 1986, hospitals

laid off an additional 1,300 workers.<sup>65</sup>

While data on individual occupational job loss is not available, we do know that the occupational breakdown in Massachusetts hospitals is as follows: registered nurses 17.5 percent; clerical workers 17 percent; health service workers 14.5 percent; technicians 6.7 percent; licensed practical nurses 5.9 percent, food service 5.6 percent; and all other workers 32.8 percent.<sup>66</sup>

During the 1980's, Massachusetts hospitals were regulated by the Massachusetts "All Payer System," from 1981 - 1984, and currently by the federal DRG system, which came into affect in 1985. The Massachusetts Rate Setting Commission, the State's regulatory health care agency, has analyzed hospital response to these regulatory pressures. Between 1981 and 1986 the average length of hospital stay fell from 8.4 to 7.3 days, occupancy rates decreased from a high of 81 percent to 65 percent, and the number of patient discharges decreased 5.4 percent.<sup>67</sup>

Although hospital expenses have increased 15 percent since 1981, this increase is almost half of what expenses were before state and federal regulations came into affect. And, although expenses have been curtailed, revenues from patient charges, operations, and patient services have increased remarkably.

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<sup>65</sup> Division of Employment Security, Employment Trends in the Health Care Industry, July 1986, p. i

<sup>66</sup> Ibid., p. 13

<sup>67</sup> Massachusetts Rate Setting Commission, Key Trends in Massachusetts Acute Care Hospitals 1981-1986, May 1987, p. 1

More specifically, charges per adjusted patient day rose almost 40 percent between 1981 and 1986, a \$1.82 billion increase in 1986 dollars (see Table I, next page), and operating revenues increased 16.5 percent in real dollars (see Table II, next page).<sup>68</sup> Net revenue hospital gains, according to the Massachusetts Rate Setting Commission, have come largely from the increased complexity of services offered by hospital units.

The upshot of these and other industry figures is that despite regulations and patient volume decreases, the financial position of Massachusetts hospitals has significantly improved in the 1980's. In 1986 dollars, Massachusetts total hospital profits rose from \$62 million in 1981, to \$127 million in 1986; and the percentage of hospitals with positive profit margins jumped from 66 percent to 77 percent.<sup>69</sup> This positive financial picture has led the Rate Setting Commission to conclude that regulation changes -- both the "All Payer System" and Federal DRG's -- have not barred hospitals from realizing healthy profit margins.

#### **MASSACHUSETTS NURSING MARKET AND SHORTAGE**

Similar to the nation as a whole, there has been a 46 percent increase in the number of employed RNs in Massachusetts hospitals since 1980. Wage increase for Massachusetts hospital RNs parallel their national counterparts. In real dollars,

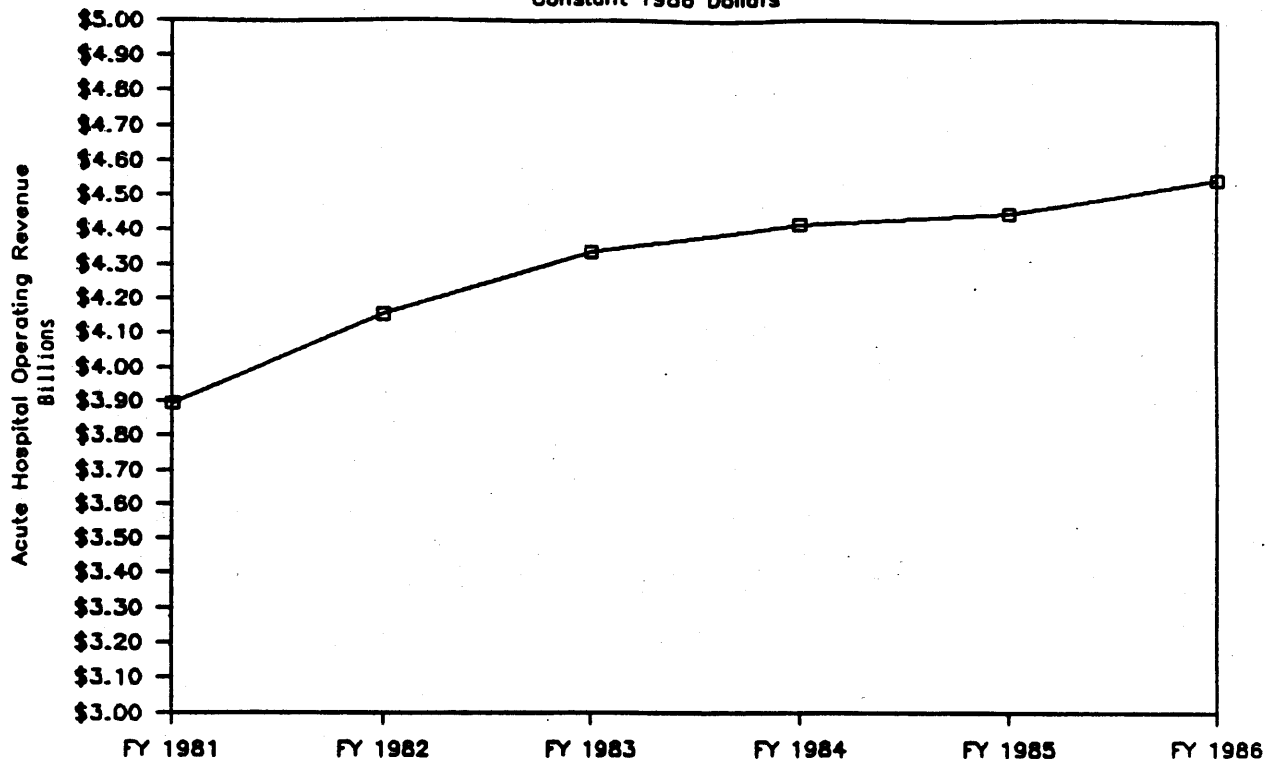
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<sup>68</sup> Ibid., p. 2,3

<sup>69</sup> Ibid., p. 1

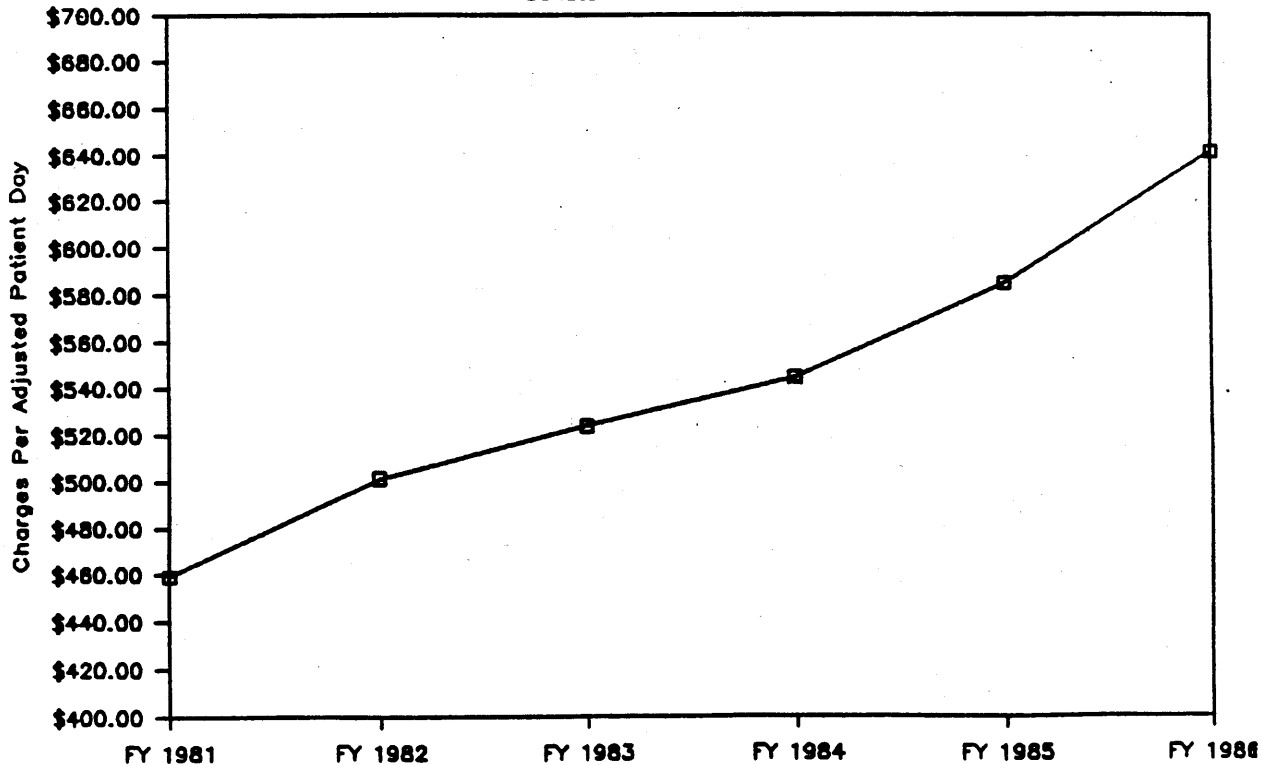
# Acute Hospital Operating Revenue

Constant 1986 Dollars



# Charges Per Adjusted Patient Day

Constant 1986 Dollars



Tables from Key Trends in Massachusetts Acute Care Hospitals 1981-1986, A Massachusetts Rate Setting Commission Report, 1987

wages increased by 11 percent in the last two years -- from \$11.86 in 1985 to \$13.35 in 1987.<sup>70</sup>

Recent Massachusetts Hospital Industry surveys suggest, however, that the state's nursing shortage may not be as severe as the national shortage. In May 1987, the Massachusetts vacancy rate was 10.9 percent, compared to the national vacancy rate of 13.6 percent. In an attempt to characterize the shortage, a recent Massachusetts Hospital Association survey found that vacancy rates are not correlated to hospital size, but that location of the hospital and nursing specialization did impact vacancy. For example, Boston's vacancy rate of 9.6 percent, considerably lower than the state's, is most likely linked to the lower vacancy rates found in the city's prestigious teaching hospitals. LPN and nurses aides in Massachusetts had vacancy rates of 8.4 and 10.5 percent, respectively.<sup>71</sup>

This same MHA survey found that hospitals are responding to RN vacancies in the following manner. Hospital administrators are leaving 44.1 percent of vacant positions unfilled; while filling the balance of positions with over time staff (13.9), float personnel (30.6), and agency temporaries (11.4).<sup>72</sup>

According to the Massachusetts Board of Registration in

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<sup>70</sup> Division of Employment Security, Labor Shortages in Human Services: The Cases of Health Care and Home Care, forthcoming, p. 4

<sup>71</sup> MHA May 1987 Survey, p.2

<sup>72</sup> Ibid., p.4

Nursing, there were approximately 87,700 RNs with active Massachusetts licenses in July, 1987. After this number is adjusted for RNs who either work in other states or are not employed in nursing, estimates of RNs working in the Massachusetts health care industry range from a low of 49,800 RNs to a high of 52,200.<sup>73</sup>

If data from the 1984 National Sample Survey (U.S. Health and Human Services department) -- which indicates that 61 percent of nurses are working in acute care hospitals -- are applied to Massachusetts 1986 data, there are approximately 30,200 to 35,900 nurses available for acute care hospital employment. On the demand side, there were approximately 34,500 budgeted full and part time positions in Massachusetts hospitals. Using these estimates, there is anywhere from a more than adequate supply of registered nurses, to a shortage of 4,000 RNs.<sup>74</sup>

A Division of Employment Security (DES) draft report approximates the magnitude of the acute care hospital shortage in Massachusetts in terms of total full and part time workers. DES' findings estimate that a 10.9 percent vacancy rate translates into 2,876 vacant full time equivalent (FTEs) positions. And, that when these unfilled FTEs are converted into an estimate of full and part time nurses (45.7 percent of RNs worked part time in Massachusetts in 1984) the vacancy rate

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<sup>73</sup> DES "Labor Shortages...", p. 3

<sup>74</sup> Ibid., p. 3

corresponds to 3,727 nurses.<sup>75</sup>

DES warned that the availability of nurses will continue to be an issue in Massachusetts as supply drops and demand increases. From 1983 to 1987, enrollments in Massachusetts nursing programs fell by over 3,100, or almost 33 percent. And, DES projects that demand for RNs will grow steadily -- by 16,000 workers, or 28 percent by 1995.<sup>76</sup>

To get a better understanding of why nurses, who were once full time, work at less than full time arrangements I interviewed 11 RNs who fell into four overlapping groups: part timers, weekenders, per diems, and agency nurses.<sup>77</sup> In addition, through these interviews I wanted to access how these nurses viewed union representation; the nature of their relationship to full time staff; if they thought non-full time nursing employment would grow in the future; and finally, what changes they thought should be made to make nursing a more desirable profession.

## **NON-FULL TIME NURSE INTERVIEW FINDINGS**

### **Hours and Wages**

Part time (less than 40 hour) RNs work at the same hourly rates as full time nurses, and most received pro-rated benefits

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<sup>75</sup> Ibid., p. 3

<sup>76</sup> Ibid., p. 4

<sup>77</sup> These 11 nurses were single, married with children, union and non-union.



for working more than 20 hours a week. (An exception to this rule was at New England Medical Center where nurses have to work 32 hours or 24 hour weekends in order to receive benefits). For the part time RNs I interviewed hourly pay was between \$17.60 and \$21, depending upon specialty, years of experience, and public/private hospital affiliation. This salary range is considerably higher than the 1987 Massachusetts average hourly wage of \$13.35. This may be because Boston area salaries are higher, but more likely because RNs have recently received 17 to 40 percent wage hikes. Also, the RNs I interviewed averaged 10 years of nursing experience, and so were on the higher end of the wage scale. Unexperienced RNs (less than five years in the workforce) generally do not work at contingent jobs because they want nursing experience; they are less likely to have family responsibilities; and because, many argue, they are not yet "burnt out."

Weekenders -- nurses that agree to work every weekend for 24 hours alternating days and nights -- are considered full time by some, although not all, hospitals. The 24-hour weekenders are paid for 36 hours -- in essence time and a half, or approximately \$31 per hour -- and receive full benefits. Regular staff nurses (full and part time) alternate day, evening, and night shifts depending upon seniority, and are generally obligated to work every other weekend.

Per Diem nurses pick up extra shifts on a periodic basis, and are a supplement to the regular staff. Per Diems, as they are

commonly called, are the equivalent of a hospital's internal temporary agency. Large hospitals may keep a per diem list of anywhere from 200 to 300 nurses at any one time, and some hospitals require a minimum number of work hours to remain on the list. Per diem pay varies, some are paid time and a half, others at their existing staff rate -- but none of them receive benefits for the hours worked. The per diems I spoke with either worked part time, and wanted extra shifts on a regular basis, but were not willing to take on full time status; or worked full time and wanted additional hours.

Agency nurses, employed by for-profit nursing temporary agencies, also mixed work arrangements -- they worked part time and temporary, 24 hour and temporary, full time and temporary, or as visiting nurses (non-hospital) and temporary. Temps made between \$20 and \$29 per hour, were paid for their particular expertise, and received more money for weekend work. They did not, however, receive benefits, nor were they paid for experience. The highest temporary rate I saw advertized was \$33 an hour, paid to specialty nurse willing to work off-shifts.

#### Relationships Between Staff and Temporaries

In addition to pay parity, full and part time nurses' job requirements are nearly identical. While part time nurses are less likely to participate in staff meetings, professional development seminars, and to be more detached from hospital politics than their full time counterparts, these differences

appear to cause only minor ripples between the two groups. While one full time non-union nurse I interviewed resented the fact that part timers rotate shifts less frequently, and per diems got first pick of over time hours -- I didn't interview enough full time nurses to make any kind of assessment.

There is, however, flagrant animosity between staff and temporary nurses. While on the one hand, some staff nurses welcomed the help the agency nurses offered, many other hospital nurses resent the fact that agency nurses are making twice their salaries, and taking on less responsibility. Every nurse I interviewed mentioned this friction.

"I feel slightly antagonistic towards temps. You may like an individual, but your first feeling is one of bitterness. That they are an invader, that they are making all this money, that they are an opportunist. Temps are not responsible to anyone, they leave at the end of the shift."

#### RN at Boston City Hospital

Depending upon the hospital, temporary agency nurses are not allowed to be "in charge" of a unit; dispense medication; assess patient condition; and administer intravenous feeding. Staff nurses, therefore, must take up the slack, and this can cause resentment. Temps are also restricted from handling acute or crisis situations. They generally attend to more stable patients -- who from a nursing standpoint are not as challenging. In return, the most emotionally demanding patient often gets dumped on the agency nurse.

Temporary nurses are also accused of fracturing care delivery, and of negatively impacting the overall nursing

profession by reducing nursing to discrete, routine tasks.. Nurse executives claim that temps undermine their efforts to position nurses as specialists who are integral to patient assessment and treatment. In the 1970's, part time nurses were accused of the same thing.

"Temps don't know policies and procedures. They don't know a patient's hospital course, nor do they have time to read the charts. They are bound to miss something."

A RN at Soldiers Home, Chelsea

Other nurses thought that the negative stories about temporaries were exaggerated, that frustrated nurses had made temps their scapegoats.

#### Union Representation and Staffing Arrangements

None of the part time nurses I interviewed thought that the union represented them any differently than the full time nurses, and all of them (with one exception) thought that the union was doing a good job in winning wage increases and additional benefits.

Unlike other unionized industries, there does not seem to be a lot of friction between full and part time union members, or staff and per diem nurses. This may be due, in part, to the fact that nursing has not experienced heavy employment losses, and so at least in terms of budgeted positions the pie has recently been enlarging. In fact, two nurses told me that the union representative in their unit was a part timer.

"The union did not exclude me when I went per diem. (although this nurse is officially no longer a union member). The union would serve my needs if I ever had a problem no matter how infrequently or frequently I worked. They would support me if I had a grievance."

Per Diem RN at Tufts New England Medical  
Former Mass Nurses Association member

Temporary nurses are not represented by a union, and few of the RNs I interviewed thought that temps should be part of the labor movement. The reasons non-temp RNs gave were that a union shouldn't take the risk of representing temps because they are an unknown, and that agency nurses have no institutional commitment to a place, so they shouldn't be awarded union status. Nurses working for agencies said that unionization was unnecessary or undesirable because the temporary agency acts as an intermediary between RNs and the hospital, and because a union might disrupt the current free market by locking in negotiated salaries for their temporary members. While there were some nurses who thought temps should be organized, they stressed it would be a difficult organizing task.

#### Why Work Part Time, Temporary, or Per Diem?

The question of why former full time nurses are now working part time, temp and per diem is an important one to get to the heart of as only one out of the 11 nurses I interviewed ever intended to return to full time nursing.

Four out of the five part time nurses who were mothers said that the main reason they were working on a less than full time basis was because of family responsibilities. It was evenly

split between those who choose to stay home, and those who were forced to because they couldn't find affordable and quality day care. Part timers also wanted more control over their own schedules, and more flexibility in the number of hours worked. Traditionally, hospitals have expected nurses to work over time, and with the shortage, RNs are working more overtime than they have in the past.<sup>78</sup> Many employers also demand that both FT and PT RNs work every other weekend.

All of the part time nurses (with the exception of one weekender) picked up extra shifts. They averaged an additional 48 hours per month, by working per diem at their hospitals, or by going outside the hospital to work temp. The main reasons these nurses gave for working additional shifts were: 1) scheduling flexibility -- the option to pick up two eight hour or no additional shifts weekly; and 2) pay, they make 50 to 100 percent more per hour than working as a staff nurse. For example, nurses work 28 hours and get paid for 36 because of weekend time and a half; or nurses work as weekenders (24 hours worked; paid for 36) plus another eight hour shift, and totalling 44 hours paid hours. Full timers also worked at a variety of supplemental arrangements. One full time nurse, who was able to land a "gem" job working weekdays 7 a.m. to 3 p.m., worked an additional two per diem shifts monthly for the extra income. Contrast that to another 40 hour RN who worked an

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<sup>78</sup> Massachusetts Hospital Association, Nursing Supply Survey, May 7, 1987

additional 26 hours weekly: 10 hours over time, and 16 hours per diem.

RNs who work 24 hour weekends don't have to sacrifice full time pay. They choose that arrangement to have more time for their families (if they have children); reduce the stress they encounter working 40 hour weeks; or because they are in school or making the transition into another profession.

Nurses work temporary because its more lucrative and less stressful than per diem or over time work, and because they want control over their schedules. Only a small minority of temps work for an agency full time; most use agencies to supplement part and full time nursing hours. One out of the five temp nurses I interviewed was a student. Another was a single mother who works full time temp; she is looking for a job outside of nursing so she can be home on the weekends and receive benefits.

#### Are Nurses Voluntarily or Involuntarily Contingent?

By standard definition, most of the part time, temp, and per diem nurses do not appear to be working at that arrangement involuntarily -- none of them said they were looking for full time RN positions, and only two part time RNs said that they could not find affordable day care.<sup>79</sup> Hospitals are looking for full time RNs, and offering incentives to attract them so

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<sup>79</sup> The lack of affordable day care is an issue that some recent union contracts have tried to address. For the RNs I interviewed it was not the pressing reason they were working less than full time.

any nurse who wants to work full time can do so provided she can meet hospital scheduling requirements.

I think its important, however, that many of the part timers are picking up additional per diem and temp shifts, and that weekend employment appears to be increasing. In other words, temporary agencies and per diem pools provide part time RNs a mechanism for achieving nearly full or full time wages and scheduling control, while not requiring them to work a stressful 40 hour week. If there was not a nursing shortage, wages were lower, and nurses did not have an agency, per diem, and weekend employment option, would full time employment increase? I think any full time employment increase would be mitigated by the fact that full time nursing is currently so stressful and unsatisfying.

While there is a down side to per diem and temporary work -- nurses aren't receiving full benefits or building up their pensions -- the pay premium and scheduling control may be compensating for that loss. So, while RN behavior seems to be economically and pyschologically rational, at least in the short term, employers do not appear to be behaving rationally.

Hospitals are paying the same or more for part timers in actual wages -- sometimes one and a half times more -- and part time benefits are at least par with full time. Also, with temporary and per diem nurses, employers are losing in terms of productivity -- these nurses often can not take on the same responsibilities as staff nurses, and they must be closely



supervised. In addition, staff morale and cooperation is being compromised, and hospitals are foregoing employee loyalty and institutional commitment that is more apt to accompany full time employment.

But a closer look suggests that hospital employers may not be acting as inefficiently as first appeared. Massachusetts hospital income statements suggest that institutions may be passing the increased cost of part time and temporary employment onto patients, insurers, and government programs: Hospital patient charges, in constant dollars, have risen every year between 1981 and 1986: unit charges per adjusted patient day went up almost 34 percent; and adjusted patient discharge cost rose 16 percent during this period.<sup>80</sup> And, while profit margins were increasing (see earlier analysis) RN wages were rising only slowly (4 % between 1984 and 1985; 7 % between 1985 and 1986). It is also true that temporary nurses, in comparison to staff, are a "fixed cost" which is appealing to chief financial officers in that hospitals do not have to pay for temporaries' sick days, vacation time, benefits, or training. But even when considering these factors -- temps are a fixed cost, and hospitals are passing along some of the increased cost of non full time employment -- it still doesn't appear that contingent nurses are a "deal." In fact as the next chapter shows, employers are trying to get rid of temporary agencies. The

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<sup>80</sup> MA Rate Setting Commission, Key Trends in Massachusetts Acute Care Hospitals 1981-1986, May 1987, p. 21

puzzle is, if employers are the "buyers" of temporary services, and there is no intermediary like a union, why don't they construct more favorable (less costly) employment terms?

The following applies prevailing economic theories to the above findings in order to understand their implications, and to contrast differences between nursing and other labor markets. Earlier I showed that the nurse labor market did not conform to standard human capital theory i.e., nurses are not rewarded for education, experience or expertise. Also, these interviews illustrate that nurse employers have deviated from neoclassical behavior by providing part timers with pay parity -- this behavior undermines full time wage premiums, and consequently reduces incentives for full timers to work hard and exhibit firm loyalty, according to standard theory.

From the institutionalist or dual market perspective I would also argue that RNs working less than full time are different than contingent workers in other secondary labor markets namely because: 1) part time RNs have pay parity or better with full timers; 2) temporaries, at least in Boston's labor market, exceed hourly full time wages; 3) part timers who work more than 20 hours per week generally receive pro-rated benefits in both union and non-union settings; and 4) at least in the Boston area, nurses can choose to work additional hours at time and a half or better. In short, RNs seem to be turning the core-periphery relationship inside-out -- almost to the extent that full time nurses are peripheral to the core of part timers and

temporaries. The next question is, why is this happening?

### Hospital Restructuring Makes RN Jobs Less Satisfying

My interviews generally support my hypothesis that deteriorating job and workplace conditions have prompted a significant number of full time nurses to cut back on hours, or to leave the profession. The overwhelming reason that nine out of 11 nurses gave for never wanting to work a full time schedule again hinges on nursing being too stressful a job to perform 40 hours a week, and weekend and over time work, they report, adds to its undesirability. One part time nurse echoed a common sentiment, "Full time nurses are hardened, they are not the kind of nurse I want to be."

Interviewees reported that full time nursing is more stressful than it was in the past because there are more severely ill patients to attend to; increased paperwork and machine tending leave less time for caretaking, which is one of the more satisfying aspects of nursing; and because understaffing, a long term problem, is exacerbated by the current shortage.

"I work on a cardiothoracic unit where we always had a 1:2 nurse - patient ratio. Now, they try to give me five patients at one time. I have to be very firm with the employer. I just refuse to work under those conditions. I tell them its not safe unless they send me another nurse."

A RN at Tufts New England Medical

This nurse's comment makes sense when considering the recent Massachusetts Hospital Association's survey which reported that

44 percent of the vacant full time equivalent RN positions were left unfilled during the week of May 7, 1987.<sup>81</sup> This anecdote is mild, however, in comparison to some of the reports nurses relayed about how the shortage is affecting the quality of nurses institutions are hiring, and the quality of care they give. A nurse at Leahy clinic relayed the following experience:

"I could tell that one of the new nurses we hired had a substance abuse problem, although I didn't know exactly what it was. I told my superiors, and they did nothing. So, I watched this nurse very closely.

"It all clicked one day after I comforted a women who was dying with cancer. She was crying and screaming in pain. I checked her chart because she wanted another shot of Demoral. At the time I didn't understand why she was in so much pain. I told her that I couldn't give her another shot because she was up to her limit.

"It finally dawned on me that the women with cancer never got her medication. The next day I checked all the medication sign outs. I realized that many were under assumed names. I eventually caught the nurse red-handed. She was signing out more medication under a patient's name who didn't exist.

"When I brought what I had learned to my supervisor, I found out she already knew this nurse had a substance abuse problem. This nurse had apparently gone through a rehabilitation program, and it was on her record. But the head nurse did nothing when I first brought my suspicion to her because, in her words, 'We're so understaffed.' I tell you, this kind of thing would not have happened in the past."

In addition to reports about unfilled vacant positions and unqualified nurses, the interviewees said that temporary nurses -- used to fill 11.4 percent of vacant positions <sup>82</sup> -- actually

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<sup>81</sup> MHA 1987 Survey, p. 2

<sup>82</sup> MHA May 1987 Survey, p. 2

increased the workload, responsibility, and stress level of staff nurses. This dynamic between staff and temporary nurses was explored earlier.

The vast majority of the nurses I interviewed also said that DRGs had heightened patient acuity, and thereby increased stress. Instead of having a mixed caseload of patients, all the patients are now very ill. While increased acuity did not seem to affect all hospital units, most RNs echoed the following remark, "Patients are not in the hospital these days for observation. If they are there, they're very sick."

Another fallout of DRGs is the increased paperwork the reimbursement system requires. About half of the nurses I interviewed mentioned that the time they now spend accounting for their hours took away from time spent administering care, which is more satisfying. The RNs I interviewed said they spend more than a half day a week doing paperwork.

"It's almost like you've got RNs doing paper work, and teckies (technicians) administering care. You know, you hear a lot about RNs not having time to give patients back rubs. Its much worse than that, I'm talking about basic care. Like making sure patients' lungs are clear, and changing dressings. I mean basic things are just not getting done."

RN, Tufts New England Medical

Many nurses also mentioned that RNs were increasingly called upon to perform additional job functions, particularly in hospitals where LPNs had gotten phased out.

"We need more ancillary personnel. Hospitals hire a RN so she can do everything. We need more clerical workers, more medical workers (technicians). Its impossible to feel like you are a professional."

A Nurse at New England Medical

In summary, changing hospital regulations have dramatically restructured nurses' job responsibilities. Restructuring has caused nursing jobs to become both more stressful and more task oriented -- while limiting the time nurses have available for care taking -- and in the end has made nurses jobs less satisfying. In short, structural factors explain nurses' increasing job dissatisfaction -- these factors cause nurses to cut back on hours or prompt them to work as temporaries, which is less stressful, although not more satisfying.

#### Long Term Problems with Nursing

In addition to hospital restructuring that has heightened stress and reduced job satisfaction, nurses report a number of long-standing problems with the profession that, they say, make it undesirable. These include low pay; undesirable hours and lack of scheduling flexibility; poor nurse-physician relationships; lack of respect; and unreceptive and less than powerful nursing management.

Undesirable hours and the lack of scheduling flexibility were two of the most frequently mentioned reasons that full time nursing was unattractive. They were also cited as one of the key reasons people had for working less than full time -- either as a part timer, weekend nurse, per diem, or temporary nurse.

Most hospitals require RNs to work every other weekend, and alternate day and night shifts -- this disrupts family and personal schedules.

After the last RN shortage in 1979, some hospitals reconfigured schedules to make them more attractive. Weekend shifts with premium pay were introduced as an incentive to get nurses to work undesirable hours, and to take some of the pressure off of the full timers. It appears, however, that hospital response to the 1979 shortage lagged -- the first weekend shifts were introduced in 1982, and until very recently there have been few other changes in the work rules governing nurses schedules.

In 1988, nurses are still voicing the same complaints about long hours, weekend work, and the lack of control over their own schedules. Given that severe shortages have periodically occurred since WWII, and that the lack of scheduling flexibility and control has long been a workplace issue, it seems that part of the explanation for the market stickiness or lack of response is an explanation that was introduced earlier: that the RN labor market functions as an oligopolistic market. Under oligopolistic market conditions, employers are not obligated to change workplace rules when shortages occur. And, although employers "pay" in terms of higher turnover, absenteeism, and growing temporary and part time ranks, they appear to be passing at least part of the cost along to purchasers of hospital services.

In addition to dissatisfaction with nursing schedules, half of the nurses I interviewed reported that they were disturbed by the relationships they had with physicians, and that patients didn't treat them with respect. While some of them said that younger doctors approached patient care in a more collaborative manner -- listening to nurse input on patient status, instead of issuing orders without discussion -- most nurses reported that the relationship between nurses and doctors is still a subservient one. This relationship -- that is predicated on traditional male-female lines -- may be particularly difficult to reform.

A few of the nurses complained about nursing management who mediate between the regular staff nurses and hospital administrators. Nursing management was described as RNs "worst enemy" because they have to carry out management's directives while having little real power to change or influence policy. Unlike physicians, RNs generally do not sit on the board of directors and therefore have limited input into fiscal or policy decision making. This is additional evidence of nurses lack of power within the hospital hierarchy.

Poor salaries were an issue for a few nurses who think their salaries were not competitive to other jobs with similar educational requirements, pressures, and responsibilities. Historically, pay has been an issue for nurses and unions have attempted to address this through collective bargaining and pay equity. Many of the part-time nurses I interviewed were



"getting around" the pay dilemma by working additional per diem or temporary shifts, and at the same time reducing their stress levels. It is difficult to know, however, how many RNs have left the nursing profession in Massachusetts and in the nation as a whole because of wage levels.

This paper will not attempt to understand why RNs decide to work full time, however, it is interesting that less than full time RNs characterized full timers as those that need nursing experience; as women who are single mothers; or as women who do not have family responsibilities. Beyond the monetary benefits of a 40 hour week, what do full time RNs gain -- in terms of advancement, professional status, experience or skills training -- by working a full time schedule?

#### Will RN Part Time and Temp Employment Continue to Grow?

"There is an element of denial among the hospitals when it comes to the nursing shortage. They think it will go away."

RN with 14 years experience

All of the RNs interviewed (11 out of 11) think the shortage will continue, and most thought that non-full time employment will continue to grow over the next three years. Part time employment will grow because: nursing is increasingly stressful and less satisfying; there is no monetary incentive to work full time, and as salaries rise the incentive to work part time increases. The part time workforce will also grow because RNs, who historically would not have re-entered the work force, do

now because families need two incomes. Temporary employment will increase because agencies offer: an enticing pay premium, whether that be full or supplemental wages; a reprieve from full time schedules; and the opportunity to go to work and school, or work and take care of family responsibilities.

A SEIU 285 representative at Boston City Hospital speculated about hospital response to increases in temporary agency employment, "Sometimes I wonder if hospitals think about how much temps are costing them. They should, we've brought it up at the bargaining table. They could be offering benefits to their full time workers instead. I think hospitals also use temps to keep unions down. In fact, temps crossed our picket lines last August."

Others thought that recent wage hikes, as well as bonuses for working consecutive evenings, nights, or weekends would dampen part time and temporary employment growth. Mass General's Boston Globe advertizement on March 13, 1988 announced a new hourly base rate of \$13.81 (a 22 percent increase), new shift differentials, and bonuses for working non-day time work. The bonuses were for \$500, \$1,000, and \$2260 for working three consecutive months of evenings, nights, and weekends, respectively. <sup>83</sup>

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<sup>83</sup> Boston Globe, "Help Wanted Section" March 13, 1988

"Hospitals are being forced to respond to the shortage and to the growth of part time and temporary employment by raising salaries. Higher wages will entice part timers and temps back into full time positions."

RN, New England Medical

#### Changes Nurses Think Should be Made

While interviewees mentioned a variety of things they said would make their jobs more desirable, there was majority consensus on three areas for improvement. In order of priority, these include: better hours and scheduling control; increased respect from doctors, nursing management, and patients; and more and higher quality staff. While pay and direct benefits such as day care, parking, and education days were important to the nurses, they did not rank in the top three choices.

The two most important changes the nurses (who were about evenly split between union and nonunion) want pivot on control, and job satisfaction, rather than on direct monetary issues. From the nurses' perspective this suggests that the nursing supply shortage and its accompanying contingency employment growth will not be brought "under control" if hospital response is limited to wage increases i.e., addressing the lack of continuous pay increase issue, and rewarding off shift and weekend work. It seems that hospitals will need to re-think other policies, namely how to increase job satisfaction for nurses who do not participate in patients' recovery to the same extent they did in the past; how scheduling is controlled (currently a management prerogative); and how nurses can take

part in hospital management decisions which today are dominated by business people and physicians.

The next chapter explores nurse employers' -- both hospitals and temporary agencies -- perspective on the nursing shortage, and recent changes in the hospital environment, plus what employers recommend as possible solutions to current staffing problems.

## CHAPTER FIVE

### NURSE EMPLOYERS

To begin to understand management's perspective I interviewed employment managers and vice presidents of nursing in two large hospitals (Brigham and Women and New England Deaconess), and one small hospital (Mt. Auburn); and principals at three temporary agencies: Americare, a small start up company; Staff Builders, an 18 year old Massachusetts based company; and Olsten, a national chain of temporary agencies.

The purpose of my hospital interviews was to get a better sense of how and why staffing arrangements have changed within the hospital; how employers think those changes have impacted hospital budgets, quality of care, and existing staff; and what hospital employers predict for the future in terms of staffing. From the temp agency principals I was interested in finding out what kind of nurses used their services and why; who their clients were; how their agency had grown; and what their long term predictions were for the temporary RN market.

### HOSPITAL EMPLOYERS

All three of the hospitals I interviewed reported changes in RN staffing patterns. Employers were using more temps, per diem pools, and part timers than in the past -- and they were concerned about this recent trend. All of them wanted to increase their full time staff to previous levels, and to use

temporary nurses on a supplemental rather than regular basis. According to a recent Massachusetts Hospital Association survey (May 10, 1987), 65 percent of the temporaries hospitals hire are RNs; 25 percent are nurses aides; and less than 10 percent are LPNs.<sup>84</sup>

The number of RN vacancies, percentage of part time RN staff, and temporary usage varies within hospitals. On one extreme, is Brigham & Women hospital whose part time staff is only 25 percent, and where temp usage is 6.2 percent (there are 75 temp nurses out of a staff of 1200 on an average day); this usage is well below the Massachusetts hospital average of 11.4 percent.<sup>85</sup> On the other end of the spectrum is Mt. Auburn hospital where part timers constitute 37 percent of the staff, and temporary usage constitutes 10.7 percent of the hospital's nursing wage and salary budget.<sup>86</sup>

Hospital management primarily attributed changes in staffing arrangements to be driven by the lack of new nursing entrants, the current shortage, and nurses' changing and increasingly negative attitude towards the nursing profession (all supply variables). At the same time, management acknowledged that nursing has become increasingly stressful, and less satisfying. Similar to the concerns nurses raised, management thought that

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<sup>84</sup> MHA May 10, 1987 Survey, p. 5

<sup>85</sup> Interview, Brigham & Women employment manager, April 1, 1988

<sup>86</sup> Interview, Mt. Auburn nurse executive, April 11, 1988

heightened patient acuity, and under-staffing had contributed to full time staff working fewer hours, and the channeling of part time and full time staff into temporary positions. A Massachusetts Hospital Association (AHA) survey of 98 hospital administrators reported similar findings. According to the MHA survey, administrators perceived the RN shortage to be driven by supply (86 percent); turnover (42.5 percent) -- this is a proxy for workplace conditions; salary (32.5 percent); and lastly, by demand (27.5 percent).<sup>87</sup>

While increased part time employment was an issue for employers, temporary employment growth topped management's list of concerns. Hospital employers said they want more full time staff because full timers are loyal and committed to the institution; cost less than their contingent counterparts; and scheduling full timers is more straightforward and less complex than part timers or temps.

In addition to foregoing the attributes full time nurses offer, employers think temporaries are less desirable than part timers because agency nurses skills are unknown; they are paid more; they don't know or understand the institution, and so can fracture care; and they put more responsibility on staff nurses, which undermines staff morale. Plus, in the words of one administrator, "Temps are one step out of my control."

All employers expected both part time and temporary employment to grow over the coming few years. Like the nurses I

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<sup>87</sup> MHA January 7, 1987 Survey, p. 2

interviewed, employers thought higher wage rates would prompt more people to work part time, rather than expand full time nursing ranks, because, they said, nurses will trade off additional wages and hours to reduce workplace stress and to spend more time with their families. Temporary agencies, employers testified, will be difficult to "get rid of" because they provide non-hospital nurses as well as full and part time staff nurses, a flexible way to supplement their income by offering a pay premium and scheduling control. Although as an employment manager at New England Deaconess, said, "We're doing everything in our power not to use agencies." <sup>88</sup>

Boston area employers have taken some steps to address the shortage, and its resultant growth in part time and temporary employment. They have raised wages -- from 15 to 40 percent -- offered bonuses for working off shifts, introduced scheduling innovations, and have heavily increased recruitment activities.

As the shortage continues to deepen, hospitals are considering additional alternatives. The most frequently mentioned solution was to add one or two more staff support positions to the nursing function -- such as a technical nurses aide and a nursing assistant (similar to the largely defunct LPN). These new positions would help reduce RN work load, and "insure that nurses don't have to do housekeeping and other chores." Employers also said that they will become more

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<sup>88</sup> Interview with New England Deaconess employment manager, April 18, 1988



creative with scheduling: offering more senior nurses weekends off; requiring shifts every third rather than every second weekend; and making permanent weekend and night positions with generous pay premiums available. Scheduling innovations have already paid off for at least one hospital. By offering 40 hour weeks with no weekend requirement, Massachusetts Respiratory recruited more new nurses in two months than they had in all of 1987. <sup>89</sup>

Finally, nursing management thought that the hospitals should be more pro-active in the legislature than they have been in the past. A nurse executive at Mt. Auburn hospital, thinks that temporary agencies have an unfair advantage in that they are the only unregulated body within a heavily regulated industry. This nurse executive endorsed the recent Mass Federation of Nursing Home's bill that would cap agency rates by setting a ceiling on charges hospitals are allowed to pay.<sup>90</sup> While originally part of Dukakis' Universal Health Care bill, this particular clause was dropped from the final version. <sup>91</sup>

When asked hospital employers admitted that they had not considered direct incentives to retain fulltime staff i.e., higher wages and increased benefits for full timers; day care; or career ladders and advancement opportunities.

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<sup>89</sup> Bennie DeNardo, "Nursing Shortage Changes Face of the Profession," Boston Business Journal, March 14, 1988

<sup>90</sup> Interview, Mt. Auburn nurse executive

<sup>91</sup> MA House of Representatives Bill No. 5000, February 25, 1988, section 25F

These findings parallel data from the May 1987 MHA survey. To help retain full and part time staff, 52 percent of hospital administrators increased scheduling innovations, and 46 percent upgraded salaries over the last year. A much smaller percentage of employers increased efforts towards providing career ladders (22 percent), or made any effort to provide child care (22 percent), both incentives that could retain full time nurses.<sup>92</sup>

### **TEMPORARY AGENCY EMPLOYERS**

Relatively new to the medical market, temporary agencies emerged in response to nursing shortages in the 1970's and 1980's, and became identifiable entities in the early 1980's. Designed as a job agency for nurses, and as a resource for employers, temp agencies are an alternative to per diem hospital pools, and to nursing registries (where self-employed nurses work for a fee).

The Service Employees International Union estimated that there were 3,000 health care temporary agencies nationwide, and that 40 percent of hospitals used temps on a daily basis.<sup>93</sup> Medical agency employment -- 9.9 percent of all temporary agency employment -- is on the rise both nationally and in Boston, according to the National Association of Temporary Services.<sup>94</sup>

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<sup>92</sup> MHA, May 7 1987, Table XIV

<sup>93</sup> 9 to 5 Report, p. 13

<sup>94</sup> Phone interview with Louise Gates Seghers, National Association of Temporary Services

The Bureau of Labor Statistics projects that medical temporary employment will increase as the U.S. population ages and requires more nursing care; as patients are discharged earlier through DRGs; and as changes in private and medicare coverage make home health care more affordable.

#### **BOSTON AREA TEMPORARY MARKET**

"I have ten times as many competitors today as I had during the last shortage in 1979."

An Americare executive; Cambridge, MA <sup>95</sup>

Although there is no parallel data for hospitals, nursing homes increased their use of temporary RNs and LPNs by 13 percent between 1984 and 1985 (the last year data is available). <sup>96</sup> And, according to MHA reports and popular press accounts, hospital temporary agency employment is growing rapidly. Hospitals that never used agency nurses before are now doing so, and agencies report that their client mix is even more heavily oriented towards hospitals. Of the agencies I spoke with, all had substantially expanded in the last few years i.e., Olsten, a national chain of temporary help agencies, opened three new health care temp agencies in Massachusetts in 1987, and grew from 35 to 50 health care

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<sup>95</sup> Interview, Americare executive, March 21, 1988

<sup>96</sup> DES "Labor Shortage..." Report

agencies nationwide since 1985.<sup>97</sup>

It doesn't appear that the agency market is saturated: none of the agencies I spoke with were able to fill more than 50 percent of the RN orders they received because of the lack of available applicants.

"We are actually providing the same number of temps as we did back in the heyday of 1978. But then we filled 75 percent of our orders, while today we are only able to fill half."

A Staff Builders executive, Boston <sup>98</sup>

These agencies paid nurses between \$17 and \$25 per hour, depending upon shift worked and nursing specialty. Hospitals pay agencies from \$25 to \$36 for these same nurses, and therefore agencies receive anywhere from \$8 to \$11 an hour per nurse, or 30 - 32 percent gross profit. Agencies do not pay for years of nursing experience, nor do they provide benefits to temps, unless a nurse works between 32 or 40 hours a week for the given agency. Agency rates have increased substantially in the last two years. During the shortage of 1979, agency nurses made \$9 an hour; and as late as 1985, averaged \$12 an hour. The agency principals predict that temps rates will continue to rise substantially, at least in the short term.

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<sup>97</sup> Interview with Olsten employment manager, April 15, 1988

<sup>98</sup> Interview with Staff Builders executive, April 11, 1988

"The pay rates will go up another 20 percent before summer is out. Generally our raises are bi-annual, but this pending increase will be the third pay raise this year. Our business is seasonal, it's usually busiest in the summer. I've never seen it this hot in March."

An Americare executive

The agency principals characterized the RNs they placed -- which varied by agency size from 50 to 366 per week -- in a number of ways. The predominant description they gave was of an experienced nurse (five years plus) no longer satisfied with hospital staff nursing, who worked 24 to 32 hours a week, and was married to a husband who had family benefits. This description characterizes about half of the temporary agency ranks, according to the interviewees. In addition, the temporary agency pool was composed of single young women who were either going to school (mostly for non-nursing related degrees), looking for non-nursing employment, or new in town; and single or divorced mothers working close to 40 hours for the agency. This latter group was fairly small among the RN ranks, but substantial among home health workers.

While acknowledging that nurses work temp for the pay premium and because they want control over their schedules -- the same reasons nurses went to temp agencies in 1979 -- agency directors said that recent changes in the hospital environment have increased the pool of temporary nurses.

"Nursing has always been a difficult job, but its become more stressful. Hospitals have turned nurses into machines, and they require them to know a lot of technical things. On top of these increased requirements is the shortage. In this environment nurses are not able to do the things that makes them feel good about their jobs and themselves, namely take care of people."

A Staff Builders executive

Ironically, the agency directors suggested that temps negatively impacted the quality of care within hospitals. One regional director of an agency who was pregnant told me she decided to have her baby at Beth Israel because it is the only hospital that doesn't use temporary nurses. Another said, "Temps don't know where the fire escape is, who the doctors are. They just came in off the street."

The agency directors I interviewed saw themselves as employers of nurses, rather than as managers of independent contractors. In that vein, these agencies pay workers compensation, federal and state taxes, employment insurance, social security, malpractice insurance, and auto insurance. They also handle payroll, and some agencies pay for required classes. In addition to carefully screening applicants, calling references and verifying licenses, these employers check up on the temporary nurses once they were placed -- one agency even performed their own on-site evaluations with hospital permission. There are, however, other agencies that do not pay any employee taxes; in that instance the nurses are considered independent contractors who are responsible for filing all of their own taxes.

Temporary agencies are positioning themselves for a

permanent place within the hospital staffing structure. Agencies have instituted "block scheduling" which guarantees hospitals a certain number of temps for a three month period. The same nurses work at the block scheduled institutions during the three month period -- this is considered desirable for all parties involved: agency, hospital, and nurse. Surprisingly, the hospital does not receive any cost break by opting for this scheduling arrangement. Mass General, which according to one source pays over \$1 million to agencies for temporary services, has considered staffing an entire floor with temporary nurses from Staff Builders.<sup>99</sup>

Agency directors also encourage temps to "act like staff," or in other words to agree to overtime hours if asked, and to pull their own weight on the job, i.e., to take on staff responsibilities so that staff or hospital management does not complain about their presence. One agency director thought that because hospitals did not take the time to orientate agency nurses, temps were under-utilized and therefore less productive. Other agencies are trying to get hospitals to pay for required RN classes, rather than picking up the tab themselves -- in short, they are attempting to shift some employer responsibility and cost back to the hospital.

While hospitals are the purchasers of temporary services, they don't appear to be exercising their role as buyers: hospitals have not yet tried to get volume discounts, bid

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<sup>99</sup> Interview with Staff Builders executive, April 11, 1988

vendors against each other, nor have they gotten together to "coordinate a response" to agency price demands. Agency directors are clearly surprised at the absence of a strategic hospital response to rapidly accelerating rates. One director thought that hospitals would inevitably band together, and that the agency market would then fall out. Another director thinks that the 1979 shortage was a perceived shortage; he believes that today's nursing shortage will fuel temporary employment growth for years to come.

Still another director thinks that even if there wasn't a nursing shortage, hospitals would use temporary agencies. This individual thinks that hospitals don't want to return to the full time staffing levels they had before DRG's were implemented. He thinks that census fluctuations (number of patients) and hospital desire to have a flexible labor force will force employers to continue using temporary agency services. Other sources suggest that RN wages plus generous hospital benefit packages come close to totaling the average cost per hour of a temporary nurse, and so hospital chief financial officers are not all that worried about increased temporary employment.<sup>100</sup>

To sum up, historical evidence suggests that past shortages -- when temporary agencies were either non-existent or had a limited presence in the marketplace -- did not bring about the kind of rapid and significant change that is benefitting RNs in

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<sup>100</sup> Bennie DeNardo, Boston Business Journal



today's market. While it is beyond the scope of this paper to quantitatively test my hypothesis about the current RN labor market -- by separating out the affects of the present shortage and the recent growth of temporary agency employment -- what has accompanied these changes has been unprecedented wage increases, premium pay for undesirable shifts, and more employer willingness to revamp undesirable working conditions. In short, it appears that temporary agencies are significantly disrupting the long term oligolophic hospital market (at least in the Boston area) and the results of this influence are, at least to some extent, benefiting nurses.

#### Advantages and Disadvantages of Nurse Temporary Employment

From the perspective of hospital employers and nurses, temporary employment offers a mix of positive and negative features.

For hospitals, the cost of temporary services probably outweighs any positive features, however, temporaries do provide hospitals the flexibility they need to deal with patient (census) fluctuations. Also, it appears that at least part of temporary service cost is passed on to patients and providers.

For the perspective of staff nurses, temporaries undermine the quality of care their units provide, reduce employee cohesiveness, and increase their job responsibilities. However, staff nurses themselves also frequently take advantage

of temporary agencies in order to supplement their full and part time nursing income.

Unlike staff nurses, nursing management has, at least publicly, taken an unequivocal strong stance against temporary usage. The American Association of Nurse Executives (AONE) released position papers warning hospital employers that temporary nurses should be used "only when there are no other resources for the hospital and not on a routine basis." AONE recommended that nurse executives consider alternative management strategies to ward off temporary agency usage. AONE developed policy guidelines for nursing management to follow if they do employ temporaries; these guidelines primarily concern nursing management control and evaluation issues.<sup>101</sup>

And, for temporary nurses themselves, while "temping" is lucrative, less stressful, and provides scheduling control and flexibility, there is a down side. Temporary employment doesn't provide career upward mobility or benefits.

Nurse's unions do not appear to have reached any consensus on how to deal with temporary or part time employment growth. However, SEIU leadership did warn its locals in a recent union newsletter that, "Agency workers are no longer really temporary. Recent surveys of administrators show they are now relying on temporary agencies to deal with patient increases and staff vacancies. This upsurge of temporaries is happening

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<sup>101</sup> Association of Nurse Executives Informational Bulletins, July 1985

at the same time that layoffs are increasing, and local unions are finding both problems in the same institution." <sup>102</sup> My concluding remarks will consider the different options nurse's unions have in responding to the growth of temporary and part time employment.

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<sup>102</sup> 9 to 5 Report, p. 13

## CONCLUSION

### HOW SHOULD NURSE'S UNIONS RESPOND?

The nursing shortage -- that started in 1986 and has been accelerating ever since -- is fueled in part by the growth of part time, temporary, and per diem employment. On the one hand, these trends threaten nurse's unions power as full time members go part time or per diem (and ostensibly have less commitment to the union), or leave the union altogether when they work as agency temporaries. On the other hand, the shortage puts nurse's unions in an opportune position to win management concessions and bring about beneficial changes. Nurse's unions -- who I think must respond to each employment group individually -- can attempt to influence change within hospitals or by exerting pressure from outside.

#### Unions and Staff Nurses

Due to the fact that part time nurses already receive "core" worker treatment (pay and benefit parity), and are largely covered by union contracts, nurse's unions can address the larger issues affecting the profession, namely those that stem from DRG regulatory pressures: increased job dissatisfaction and deteriorating workplace environments.

It will probably take a few more years to fully assess how DRG's have impacted nurses' employment conditions, as well as

how these pressures have influenced patient care<sup>103</sup>. I think that only after there is some consensus on the effects of DRGs we will see any major changes in the way payment and regulatory systems are structured. In light of this reality, nurse's unions should probably concentrate on more immediate solutions, while trying to raise public consciousness about DRG's damaging effects.

For example, nurse unions could bargain for a reduced full time work week -- from 40 to 35 or less -- at the same pay level.<sup>104</sup> In return, unions could guarantee that if 32-hour-a-week full timers pick up additional shifts, they will do so through the given hospital's per diem pool.

From the hospital's perspective, this solution could reduce temporary employment, reward full time nursing staff, increase continuity of care, and most importantly, help to arrest the current nursing shortage. From the full time nurses' or union's perspective, 32 or 35 hours a week could reduce job stress, reward nurses adequately for their full time service, and help to bring about reasonable staffing levels.

At the same time nurse's unions could be pressuring employers to improve incentives that retain staff -- career ladders, day care, paying nurses for their areas of expertise.

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<sup>103</sup> A recent study by Pat Prescott found that states with high medicaid usage -- and consequently heavy DRG regulation -- have higher mortality rates than states with low medicaid usage.

<sup>104</sup> Discussion with Roslyn Feldberg, research director for Massachusetts Nurses Association

Also, they could negotiate for more ancillary personnel so nurses have time to administer care, not just "machine tend" or fill out DRG paperwork. Finally, nurse's unions could use their current market power to gain further discretion over management policy and fiscal decisions i.e., nurse unions could pressure management to put a nurse or nurses on the board of directors. Nurses' increased managerial input could elevate their status in the hospital, as well as open up the possibility of joint problem solving around how to revamp DRG-initiated policies within the hospital that fracture nurses' jobs, and ultimately the care they are able to give.

#### Unions and Temporary Employment

Nurse's unions can respond to the current temporary employment surge in a variety of ways. Two possibilities are unions offering temporaries associate union membership, or unions organizing their own nurse temporary agencies.

By paying the union a small monthly fee, associate nurses could have the support of a union community, and access to some union benefits, although they would not have direct negotiating power over wages. The benefits nurse's unions could offer to associate union members include labor market information, payment for required nursing education classes, credit cards at a reduced rate, as well as limited medical and life insurance (a benefit that hospital employers are currently responsible for providing). From the labor movement's perspective,

association union membership is desirable because it orientates workers towards future full time union membership, and reduces the likelihood that management will be able to use temporaries against regular staff i.e., in a strike situation. The challenge with this union solution would be to get employers to broaden bargaining units, and recognize temporary or per diem workers as associate union members.

The down side to this solution is that associate union membership would need to be "won" in year-end contract negotiations which means it may take a long time to institutionalize. Also, while it is not problematic in today's temporary market that nurses do not have collective negotiating power over wages, things could change to nurses' detriment in the future i.e., if pressured by hospitals temporary agency directors could cut RN hourly wage rates while maintaining agency service fee levels and profits.

Another possible solution is union nurse temporary agencies. Similar to the construction unions who have long ran hiring halls, union RN temp agencies could secure exclusive contracts with hospitals to provide them with union temporaries,<sup>105</sup> while providing nurses a continuous link to the labor movement, and helping retain and even increase union leverage with employers.

The benefit to union temps would be enhanced job security, some sort of wage protection, labor market information, and

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<sup>105</sup> These contracts could be similar to current temporary agency block scheduling agreements with hospitals.

benefits. The fees that the union temp agency obtained from RN placements could be channeled back into the union coffer to pay for temporaries' benefits and services such as medical and life insurance, education classes, etc. From the hospital's perspective, the advantage of union over non-union temporaries are the following. Given that union agencies would be less interested in realizing a tremendous profit, they could undercut prevailing temporary agency rates by reducing service fees (currently about 30 to 32 percent of total cost) while continuing to maintain high RN hourly wage rates. Also, the union could ensure more consistent quality temporaries -- presently some nurse temporary agencies are run by non-medical staff who are not experienced in the nursing field. And finally, union temp agencies would guarantee a smoother, more direct set of relationships between hospitals and the nurses they employ.

While there are many advantages to union temp agencies, they may be difficult to get off the ground for a couple of reasons. First, hiring halls generally function in markets where the union has monopoly control over labor supply. In the nursing market, union temp agencies would have to compete with established and profitable temporary agencies to gain leverage, and the competition is likely to be fierce.

Secondly, a union temporary agency would require intra-union cooperation, and depending upon the market, multi-union sponsorship and management. This type of cooperation may be



difficult to engender in local labor markets where unions are competitive i.e., Could SEIU Local 285, the Massachusetts Nurses Association, 1199 and other Boston area health care unions support a supra-union health care temporary agency?

Finally, it's possible that the creation of union temporary agencies would endanger labor management relations, and conceivable that employers would unofficially boycott union temporaries.

#### **FINAL RECOMMENDATIONS**

Like most unions, nurse's unions have limited resources and therefore must decide between a variety of solutions. Given that nurse's unions have increased leverage with employers because of the shortage, I think they should first concentrate efforts on securing a 32 or 35 hour full time work week for their members. While this is a short term solution to deteriorating job and workplace conditions, it will take a tremendous amount of time, and commitment on the part of many groups (the government, the unions, patient advocates, and employers) in the coming years to restructure the DRG system, which is largely responsible for the recent deterioration. At the same time, I think nurse's unions should take the lead on evaluating the effects of DRG's on patients and hospital workers, particularly nurses. Health care unions could join with elderly groups, advocates for the poor, legislatures, and others concerned about DRG's damaging effects by setting up a

special national commission to evaluate the kind of care being provided by hospitals today.

To address the issues surrounding temporary employment growth, I would recommend that unions offer temporary nurses associate union membership, rather than channeling resources toward setting up union nursing agencies. I think the associate union solution is more viable for two reasons: 1) given that union temporary agencies are likely to face all kinds of barriers and obstacles from hospital employers, other unions, and for-profit temporary agencies, and 2) because existing temporary agencies already seem to be significantly disrupting the long term oligopolistic hospital market (at least in the Boston area) with results that benefit nurses. Also, in light of the fact that temporaries presently constitute around 11.5 percent of hospital staffing, it seems that the potential resources unions would have to marshal to set up union temporary agencies would be excessive when considering membership demands as a whole.

In summary, nurse's unions resources could be put to better use by reducing full timers work week; increasing incentives to retain nurses such as paying for nursing specialization, child care, and other benefits; and taking the lead to revamp the current regulatory system that both undermines nurses' jobs and the care patients receive.

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