SELECTED REFERENCES

INDUSTRIAL RELATIONS SECTION Princeton, NJ 08544
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RESTRICTURING IN NURSING:
IMPLICATIONS FOR ORGANIZING**

Becker, Edmund R. and Jonathon S. Rakich. "Hospital union election
activity, 1974-85," Health Care Financing Review (UMI Infostore, 500
pp. 59-66. $50.00, issue; $9.75, article.

The authors review hospital union activity for the ten-year period following
passage of the 1974 amendment to the Taft-Hartley Act, by analyzing union,
election, hospital, and environmental characteristics. Their study contrasts
National Labor Relations Board Monthly Election Reports data and American
Hospital Association Annual Survey of Hospitals data for 1980-1985 with
earlier data and shows that while union success rates in hospital elections have
remained constant, the total number of elections in hospitals has declined. While
overall union victories as a percent of elections declined only one percent (from
48.6 to 47.6 percent), the percent of hospitals with elections went from 16.2 to
12.8. Dramatic differences occur depending on hospital characteristics (i.e.,
whether or not the decision to hold a union election was made in nonprofit,
nonreligious hospitals) and area characteristics (i.e., geographic regions that
have a strong history of supporting union election activity).

Brider, Patricia. "Where did the jobs go?" American Journal of Nursing (535
W. 57th St., New York, NY 10019), April, 1993. pp. 31-40. $4.00, prepaid.
The author reports on the newest phase in the surge and ebb of nurses supply
and demand, from the shortage of the late 1970s and the corresponding hike in
nurses' salaries to the elimination of positions in response to DRGs and the much
lower rate of salary increases in the early 80s followed by the sudden severe
shortage of nurses and enrollments that revived salary growth in 1987. By 1987
health care employment was booming and student enrollments increased
sharply at the same time that the economic recession deepened. Pay raises began
shrinking with the turning point occurring late in 1992. Since then health care
unions have moderated demands and tactics in dealing with management,
though nurses who are organized maintain their competitive edge, particularly
in salary remediation, over non-union RNs. The current trends are: 1) a sharp
decline in vacancies and turnover, 2) an increasing number of layoffs, unit
 closings and consolidations, staff reassignments, and deployment of LPNs, 3)
reduction in hours, 4) cutting incentives and demanding larger contributions to
health care coverage, and 5) implementing merit instead of across-the-board
raises. Running against the trend are the salary increases for top nursing
executives, nurse practitioners, and clinical nurse specialists. Additional citations
about the supply of nurses can be found in Nurses: manpower supply,
needs, and demand (Jul 82-Present); citations from the NTIS Bibliographic
Database, November, 1994, Order No. PB95-856548, U.S. Dept. of Com-

* Prepared by Linda Oppenheim, Social Science Reference Librarian.
** Items on this list should be ordered directly from the publisher. Addresses are given in
connection with each reference.

The author reviews the decisions and rules that have been generated by the courts of appeal and the NLRB since 1974 when Congress amended the National Labor Relations Act to cover the new, broadly defined employer category of "health care institutions," including nonprofit institutions. In doing so Congress both guaranteed the organizational and representational rights of health care employees and left open the possibility of the proliferation of bargaining units in the health care industry. Congress feared that a multiplicity of bargaining units would create an unstable labor situation that would have a negative impact on patient care. It has been left to the NLRB and the courts to determine how many units constitute proliferation. In 1987 the NLRB made its historic announcement that it would finally use its rulemaking powers to determine appropriate bargaining units in health care institutions and bring uniformity and stability to its health care bargaining unit policy. In a related article, ("Nurses: supervisory status or union solidarity?" *Personnel*, UMI Infostore, 500 Sansome St., Suite 400, San Francisco, CA 94111-3219, September, 1989. pp. 12-21. $50, issue; $9.75, article) Marco L. Colosi and William A. Krupman address the question of whether nurses with supervisory authority should be excluded from the eight bargaining-unit scheme established by the NLRB ruling in 1987. They predict that combining previously separate and homogeneous units will result in a lower rate of union victories in elections; a hospital’s probability of remaining union free increases by 27% when the units are combined.


This article surveys cases involving solicitation/distribution rules. The courts have consistently evaluated these rules on the basis of the special nature of the hospital setting and the need to minimize or prevent the disruption or disturbance of patient care. The courts’ decisions demonstrate two requirements: 1) the hospital’s rules must be based on the impact on patient care, and 2) the rules must not be overly broad, particularly in their treatment of off-duty or free time, enforcement, locations, or the form of solicitation or distribution involved. The author advises hospital administrators to consider the individual characteristics of a given location when publishing distribution and solicitation rules—the physical layout, the type of work performed there, and the availability of alternate space.


Using seven case studies and numerous interviews, the author examines the internal strategies used by health care organizations to contain costs including total quality management, work restructuring, compensation, and employee participation innovations. The study focuses on how these changes affect the quality of care and services delivered, the care providers including registered nurses, and the cost. Preliminary findings indicate that the results are mixed for patients, employees and the institutions themselves, particularly in terms of work restructuring. The desire to deliver more services in less expensive outpatient and homecare settings and other cost-savings innovations results in
a reduction in hospital employment where there are better paying, often unionized jobs and concurrent growth in other health care environments where pay is generally lower.


This article presents the results of surveys of nurses and hospital administrators about the effect of collective bargaining on health care institutions. Among the responses: 50 percent felt that collective bargaining had improved their stature as professionals; 80 percent felt that their standard of living had improved because of collective bargaining; 66 percent of the nurses felt that their job security had been enhanced; and 39 percent felt that they had a greater voice in decision-making. Not surprisingly, there was a significant difference between the responses of the nurses and the hospital administrators about the appropriateness of nurses belonging to a union, with 70 percent of the nurses favoring the idea and 77 percent of the administrators disagreeing. As to the impact of unionization on patient care, 42 percent of the nurses felt that care had improved, 25 cent saw a negative effect, and 33 percent felt there was no change. Eight-four percent of the administrators felt that the quality of patient care had deteriorated because of collective bargaining.


This survey presents data on elections since the NLRB rule (developed in 1987 and upheld by the Supreme Court in 1991) defining eight broad categories for separate bargaining units went into effect. Among the report's conclusions are: the greatest level of organizing activity is taking place in units of skilled maintenance workers and registered nurses; in some cases lengthy hearings and employer challenges still persist despite the rule; in elections held, representation has been rejected more often than accepted; and the most active unions have been the International Union of Operating Engineers and state affiliates of the American Nurses Association. Included with the report are the NLRB General Counsel's guidelines concerning application of the Board's health care bargaining unit rule and memorandum on health care unit placement issues. For an update see BNA Special report NLRB health care bargaining unit rule having little effect on union activity, 1993, 10pp., (BNA Plus, 1231 25th St., N.W., Washington, DC 20037. $27.00).


The author attempts to explain why there was no dramatic increase in union organizing campaigns in private hospitals following the 1991 Supreme Court decision that upheld the NLRB's ruling about bargaining units. He states four reasons unions have difficulty with hospital elections: 1) Because their experience is in industry rather than hospitals, union organizers have difficulty in identifying and addressing issues; 2) Unions outside the health care industry are more successful in elections in nursing and group homes where the work force is less complex than in hospitals; 3) There is an increasing number of employees whose mother tongue is not English; and 4) Hospitals have effectively used consultants to persuade employees not to call for union elections. According to a union official, unionization will be facilitated by a complete reform of current labor laws to allow such things as equal access to workers.

The authors highlight the American Nurses Association as the only major professional association to adopt collective bargaining. By the 1940s the ANA endorsed collective bargaining as the means for its members to counter low pay and onerous working conditions. Contract negotiations proceeded slowly until the passage of the 1974 amendment to the NLRA which extended coverage to nonprofit hospitals. Competition from other unions impelled ANA's involvement in collective bargaining. The authors cite nurses' strikes, the inclusion of health care workers other than nurses in bargaining units, and professionalism versus unionism as controversial issues the ANA has handled. Obstacles to organizing include lack of competition among employers, substitution of lower-paid licensed practical nurses for registered nurses, and anti-union efforts in the private health care sector where 80 percent of nurses work.


A survey questionnaire was distributed through the September, 1994 issue of *American Nurse* and was answered by 1835 ANA members, nearly two-thirds of whom are staff nurses. More than two-thirds of all respondents said that the number of registered nurses in their place of employment had been reduced either by layoffs or attrition in the past twelve months. Reasons cited for the reductions included a decrease in the number of patients treated, increased profitability, adjustments for budget cuts and/or reduced revenue, becoming or remaining competitive, a weak local economy, mergers or acquisitions, loss of beds, loss of managed care contracts, implementation of new patient care models, and anticipation of health care reform. Respondents also reported the effects of resulting massive increases in workload. Three-fourths of the respondents who reported a reduction in RNs also felt that the quality of patient care had been degraded; two-thirds of this group felt that patient safety was also adversely affected. Errors cited included medication errors, accidents such as patient falls and fractures, and numerous unnecessary patient inconveniences.


The authors use information collected from two national samples of acute care hospitals with zero to ten bargaining units to show that the following assumptions that concerned Congress in passing the 1974 Health Care Amendments to the NLRA were greatly exaggerated: (1) bargaining unit proliferation would cause patient care disruptions because of jurisdictional disputes and work stoppages, and (2) hospital costs would increase because of wage leapfrogging. Only hospitals with five or six units had wage settlements that were higher than one unit hospitals and only for two of the six occupations studied. Only hospitals with three or four units had more work assignment disputes than hospitals with one unit. There was a greater tendency to strike in hospitals with more bargaining units. However, the chance that any one negotiation resulted in a strike was not consistently related to the number of bargaining units.