

# HEALTH/PAC BULLETIN

Health Policy Advisory Center

Vol. 18, No. 3 Fall 1988



**HOME CARE  
EMPLOYEES**

I AM NOT  
ASIAN

**UNITED THEY WON**

Contract Victory for Home Care Workers page 4

# Health Policy Advisory Center

Since its inception in 1968, the Health Policy Advisory Center—known as Health/PAC—has served as a unique progressive voice for changing consciousness on domestic and international health priorities. Through the *Health/PAC Bulletin* and the books *Prognosis Negative* and *The American Health Empire*, and in its outreach to a national network of grassroots activist groups, Health/PAC continues to challenge a "medical-industrial complex" which has yet to provide decent, affordable care.



Design Maggie Block, *Three to Make Ready* Graphics

Typography First Galley Typography

Printing Print-Rite Press

Illustrations Phyllis Helland

Front Cover Photo Home care worker on picket line. George Cohen, DC 37.

Back Cover Photo Nurses picket Santa Fe Hospital, Neil Jacobs, *Albuquerque Journal*.

## IN THIS ISSUE

### Home Is Where the Patients Are: New York's Home Care Workers' Contract Victory

Barbara Caress relates her experiences as a consultant in the home care workers' contract victory. . . . . 4

### Ordered to Care: Demystifying Nursing's Dilemma

Patricia Moccia reviews Susan Reverby's history of nurses in a bind: caring in an uncaring society. . . . . 15

### Nursing and Caring: Lessons from History

An interview with Susan Reverby, former Health/PAC staffer and author of *Ordered to Care*. . . . . 20

### People Power vs. the Almighty Dollar: How Democratic Management Can Help Transform the HMO's

Harry Krulewitch argues for democratically controlled health systems as the antidote to corporate medicine. . . . . 24

### South Africa's Reign of Terror

Mervyn Susser reports on the Pretoria regime's attacks on health in southern Africa. . . . . 28

### Vital Signs

Notes on news, including parental consent for abortion, new health workers and new bargaining units in health. . . . . 30

### Watching Washington

Barbara Berney talks trash: incineration, recycling source reduction. . . . . 32

Letters . . . . . 34

## Health Policy Advisory Center

17 Murray Street New York, New York 10007 212/267-8890

Health/PAC Bulletin

Volume 18, Number 3 Fall 1988

*Board of Editors* Tony Bale, Robert Brand, Robb Burlage, Anjean Carter, Robert Cohen, Sally Guttmacher, Feygele Jacobs, Mark Jobson, Louanne Kennedy, David Kotelchuck, Ronda Kotelchuck, Arthur Levin, Cheryl Merzel, Patricia Moccia, Regina Neal, Tammy Pittman, Hila Richardson, Pam Sass, Herbert Semmel, Hal Strelnick, Ann Umemoto, Richard Younge.

*Executive Editor* Joe Gordon

*Assistant Editor* Caren Teitelbaum

*Staff Editor* Ellen Bilofsky

*Intern* Anna Reisman

*Associates* Carl Blumenthal, Pam Brier, Des Callan, Michael E. Clark, Mardge Cohen, Debra De Palma, Susan Edgman-Levitan, Barry Ensminger, Peg Gallagher, Kathleen Gavin, Dana Hughes, Marsha Hurst, Mark Kleiman, Sylvia Law, Alan Levine, Judy Lipshutz, Joanne Lukomnik, Steven Meister, Kate Pfordresher, Susan Reverby, Leonard Rodberg, Alex Rosen, David Rosner, Diane St. Clair, Gel Stevenson, Rick Zall.

© 1988 Health/PAC. *The Health/PAC Bulletin* (ISSN 0017-9051) is published quarterly in the spring, summer, fall, and winter. Second Class postage paid at New York, N.Y. Postmaster: Send address changes to Health/PAC Bulletin, 17 Murray St., New York, N.Y. 10007. *The Health/PAC Bulletin* is distributed to bookstores by Carrier Pigeon, 40 Plympton St., Boston, MA 02118. Articles in the *Bulletin* are indexed in the Health Planning and Administration data base of the National Library of Medicine and on the Alternative Press Index. Microforms of the *Bulletin* are available from University Microfilms International, 300 Zeeb Rd., Dept. T.R., Ann Arbor, MI 48106. <9>

MANUSCRIPTS, COMMENTS, LETTERS TO THE EDITOR, AND SUBSCRIPTION ORDERS should be addressed to Health/PAC, 17 Murray St., New York, New York, 10007. Subscriptions are by \$35 membership for individuals. Institutional subscriptions are \$45.

# Caring in a Care-Less Culture

**T**he recent contract victory of New York City's unionized home care workers represents a historic achievement for a group of health care workers who have long been publicly invisible. Unfortunately, the fight to improve the lot of these workers—and the people they care for—is far from over.

Despite strong consensus across the political spectrum that the *concept* of home care is a practical and humane way to help meet the nation's expanding long-term care needs, there is little support outside of organized labor for providing these mostly black and Hispanic women workers with decent training, wages, and working conditions. We hope Barbara Caress's story will be useful to organizers elsewhere as a primer for building support for the majority of home care workers who have yet to be given the time of day in city and town halls across the country.

The New York City victory is but a chapter in a larger national story encompassing the lives of hundreds of thousands of workers and clients. The nation's politically powerless home care workers, like the New York City workers whose faces and words appear in these pages, care for people very much like themselves. They are employees—one might even say captives—of a fast-growing industry in which the poor care for the poor, and where opportunities for growth and advancement simply don't exist. Like their bedside counterparts in hospitals and nursing homes, they have little or no say over their working conditions, or, more precisely, over their *conditions of caring*. As long as home care workers remain voiceless and locked out, the quality of care offered through the nation's fledgling home-care system can only resemble the worst of the larger institutionalized health care industry.

The conflicts and struggles arising out of this dilemma of carers who are not themselves cared for are taken up elsewhere in this issue by historian Susan Reverby, by her interviewer, *Bulletin* editor Ellen Bilofsky, and her reviewer, Health/PAC board member Pat Moccia. Serving as the centerpiece of their discussions is Reverby's book *Ordered to Care: The Dilemma of American Nursing, 1850-1945*, which recognizes from the first that nurses, because they are members of a predominantly female work force, operate under immense cultural pressures to perform (read "care") at a level of commitment that far exceeds what is fair and reasonable for the low wages they earn. The crisis of caring resides not so much with nurses but with the larger culture, which is quick to blame its women workers, whether they labor in exploitive cotton mills, chicken-processing plants, or hospitals.

The general problem of democratizing the workplace for all health care workers and their patients is

the subject of an article by Harry Krulewitch, a physician who has extensive experience working in democratically managed health clinics. Krulewitch argues that it is in the best interests of physicians to resist the growing proprietary forces in health care and to form alliances with other care-givers and community members to build publicly accountable health systems that serve their mutual needs. His idea appeals to us because it underscores a point that this magazine has been advocating for 20 years, namely, that only a health care system that's accountable to local communities and its own employees—whether they wash floors or perform brain surgery—can provide health care that is responsive to public needs rather than professional prestige or private profit.

—Joe Gordon, Executive Editor



John C. Goodwin, United Methodist Board of Global Ministries

# *Home Is Where the Patients Are*

## New York's Home Care Workers' Contract Victory

BARBARA CARESS

*//M* Every morning I say to myself, There but for the grace of God..." says Willie Sutton, a 45-year old mother of two, whose job it is to care for an 88-year-old woman with severe heart disease and arthritis. Eight hours a day, five days a week, Mrs. Sutton gets her disabled, sick, and irritable patient toileted, bathed, dressed, medicated, and fed. In addition to her patient-care responsibilities, she cleans the apartment, does the laundry, shops, and cooks.

For her labors, Mrs. Sutton had been getting paid \$4.15 an hour, with no overtime pay, no health insurance, no pension, and no job security. If her patient required 24-hour care, Mrs. Sutton was paid for only 12 of those hours.

Willie Sutton is one of an estimated 70,000 people who provide home care for New York City's sick, disabled, and elderly. I first met her two years ago, when I was asked to assist the staff of Local 1199, the 80,000-member health care workers' union that represents Mrs. Sutton and 20,000 other employees of the New York City home care system. The union, one of three representing home care workers in New York, sought a strategic understanding of the industry to arm it for an upcoming contract battle with the city and state. Despite the fact that I had no particular knowledge of home care, I thought my experience as a health policy analyst and planner in the city's health care system would provide a decent enough grounding to quickly figure it out. I was wrong.

I took the job already believing that whatever it was these workers did, they deserved a living wage. But before long, I discovered that this was more than a typical union struggle of health care workers. The more I learned about the home care system and the workers, the more appalled I became at the exploitive working conditions and the insecurity of their livelihood. They labor in a system built on the powerlessness of its mostly minority, often immigrant, and overwhelmingly female labor force. It is held together by the decency of the workers and their commitment to their patients.

The size and growth of the system was for a long time a closely held secret among a small number of state and city regulators. Few people knew much about home care, and even fewer cared about the

plight of the workers. There was much to learn, much to be done, and there is still more that needs to be accomplished if these workers are to continue to make progress. What began for me as another job, another client, emerged as something far different. I was to become not merely an expert or technical advisor writing background papers or costing out settlements, but an advocate for a cause.

### The Long March

On March 31, 1988, a jubilant Dennis Rivera, the executive vice-president of Local 1199, announced a stunning victory for that cause. Governor Mario Cuomo's administration, after long resistance, had just agreed to fund a 53 percent wage increase and to create a decent health insurance plan for the workers. (While the city controls the purse strings/the state is the major funder of home care services.) These long overdue gains were the fruits of the Campaign for Justice for Home Care Workers, launched and maintained through the joint efforts of Local 1199 and District Council 1707 (AFSCME), another of the unions representing the home care workers. In just over a year's time, it was joined by a coalition of the nonprofit employers and virtually every local politician of even a vaguely liberal stripe. The workers, no longer invisible, were recognized and even celebrated by the city's major newspapers and television stations. Justice for home care workers had been transformed into a widely endorsed public cause.

*Home care is the long-term care analogue to hospital deinstitutionalization.*

While the victory was sweet, the workers had waited a long time for some meaningful benefit from their labor union membership. Fifty thousand of the home care workers employed through vendor contracts with the City of New York are represented by three prominent labor unions. Every three years, Local 1199 of the Retail, Wholesale Department Store Union (RWDSU),

*Barbara Caress is a health policy consultant in New York State and a former staff member of Health/PAC.*

**Cardinal O'Connor and Jesse Jackson at a joint press conference in May 1987.**

DC 1707 of the American Federation of State, County Municipal Employees (AFSCME), and Local 32-B and 32-J of the Service Employees International Union (SEIU) independently went through the motions of negotiating new contracts. After nine years, the workers had gained an hourly wage rate of only 80 cents above the minimum wage. They had also won a small seniority differential and inadequate vacation and sick leave benefits.

This time around, the new leadership of Local 1199, recently elected after a bitterly fought campaign for control of the union, was determined to break through and get a contract that came closer to paying a living wage. The question was *how?*—how to force home care agencies, the city, and the state to spend far more than they wanted to for employees who worked alone in 50,000 different work sites? How to garner public support for people whose labors were all but invisible as they cared for poor patients in poor communities? How to win a radical change in wages and benefits for workers who could not use labor's most powerful weapon—the strike?

The Campaign for Justice for Home Care Workers was equal parts muscle and image. The muscle was

flexed by two of the three unions, Local 1199 and DC 1707, who, with the support of Jesse Jackson, put their collective organizational and political clout on the line. And the image was the reflection of a well-coordinated media campaign to portray the plight of these workers as a matter worthy of widespread public support.

**The Economics of the System**

Following the scandals of fraud and abuse in New York City's nursing homes during the 1970's, publicly funded home care programs mushroomed as an alternative form of care for the chronically ill and the elderly. The president of the United Hospital Fund, Bruce Vladeck, summarizes the changes this way: "In a relatively short period of time we have transformed our entire system of care from one dominated by nursing homes to one in which a growing majority of services are provided to people in their own homes." The number of patients receiving home care doubled between 1980 and 1987. And, because increasing numbers of them required round-the-clock or seven-day-a-week care, expenditures grew fourfold—from \$200 million to \$800 million a year.

This transformation was spurred not only by fear of



V

;?>

htf .-\* y <#&

**Local 1199 Executive Vice President Dennis Rivera (left) and union members after a meeting at union headquarters.**

scandal but by the fiscal implications of New York City's changing demography. People age 85 and over are the city's fastest growing population group, with their numbers expected to increase by 130 percent between 1980 and 2000. Without home care, half of them, or 90,000 people, would need to be in nursing homes. At the same time, after a slow-down in the -1970's, approvals for new nursing home construction were virtually halted in the early 1980's. In Brooklyn, the city's most populous borough, for example, no new beds have been added for 11 years. The current and foreseeable supply of nursing home beds has plateaued at about 40,000. The cost of supporting patients in these beds topped \$1.5 billion in 1986, of which \$1.2 billion was public money.

Home care is the long-term care analogue to hospital deinstitutionalization, costing about half as much as nursing home care. In 1987, approximately 43,000 New York City residents were being cared for daily in Medicaid-financed long-term home care programs at an annual cost of \$700 million, compared to over \$1.2 billion in Medicaid money spent for 38,000 nursing home residents.

Like many other of the best laid plans of New York's policymakers, the home care system is unraveling. Home care is a less costly alternative to nursing home or hospital care only if it is provided by low-wage earn-

ers for just a few hours a day. Without low pay, it's more costly. The reason is simple: one-on-one coverage is extremely labor intensive. Paying as little as \$6 an hour for 24 hours of care would cost \$144 a day or 50 percent more than the typical nursing home.

To keep home care cheap, wages had to be kept very low. But this strategy too has a price. Because there are numerous less-demanding jobs that pay equivalent wages, the home care industry faces a severe labor shortage. A 1988 report by a special New York State Task Force on Health Personnel documented a statewide vacancy rate of 11.4 percent in home care positions, a shortfall even more severe than that of the much-publicized nursing shortage.

#### Defining the Problem

When the current leadership of Local 1199 assumed office in June 1986, the plight of home care workers was not first on their list. After an extremely combative campaign in which Georgianna Johnson unseated incumbent president Doris Turner, the new union leaders faced a myriad of difficult problems. Chief among them was the challenge of negotiating a final contract for the hospital workers, an agreement that had yet to be completed despite a bitter, unproductive strike that stretched on for 47 days. The insurgent leadership inherited a union riven by deep political



NOSp||||

mjS ^tdr

i\*N> %α  
V. %



Home care workers at May 1987 City Hall rally led by Jesse Jackson.

and ethnic divisions and almost equally divided between pro- and anti-Turner camps. The new leadership retained few of the old pro-Turner organizing staff, and only a handful of new staff members had extensive organizing experience.

In the home care area, the union's internal weaknesses were particularly acute. Neither of the officers assigned to home care had any special knowledge of the system or ties to home care workers. Aside from hiring new staff, their first order of business was to get to know the workers and develop an understanding of the industry's history and structure. Hard work and long hours accomplished the first. The latter I was able to help with. The story wasn't, as I had so confidently assumed, just another variant of health industry unionization. Home care workers, although 20,000 strong in the 80,000-member union, had been organized in a manner parallel to the growth of the system itself—that is, haphazardly, as a result of a weird confluence of factors.

New York City's massive long-term home care system was created in part by the welfare rights movement of the late 1960's, and its unionization was in part a creature of the city's fiscal crisis. Beginning in 1967, welfare rights groups, most notably the National Welfare Rights Organization (NWRO), mounted large-scale campaigns to maximize welfare entitlements.

One of the little-known benefits included in New York State's Medicaid program was home care. As both a strategy and a service, NWRO organizers encouraged elderly and disabled Medicaid recipients to hire neighbors, often fellow recipients, as home care workers. These workers were, in effect, employees of the patients. They were paid by two-party checks issued jointly to the worker and client.

*Like many other of the best laid plans of New York policymakers, the home care system is unraveling.*

For a decade, the system grew in an unregulated, uncontrolled, and largely unnoticed fashion. Unnoticed, that is, until the inevitable scandal. In 1976-77, then City Council President Paul O'Dwyer exposed a system rife with bureaucratic incompetence, ineffi-

**Local 1199 members hold vigil for basic rights  
of New York City's 70,000 home care workers.**

ciency, and outright fraud. Some workers waited months for their pay checks, and many checks were issued to non-existent workers.

City welfare officials considered three possible remedies. They could maintain the existing system with increased scrutiny and controls. They could hire home care workers directly as city employees. Or, they could find someone else to take responsibility for the workers. The first alternative was thought to be administratively unmanageable, and the second deemed too expensive at a time when city government was laying people off. The third alternative, contracting out the system, was considered the only practical choice.

*To keep home care cheap,  
wages had to be kept  
very low.*

With one throw, the contracting-out solution killed two tough political birds. In addition to bringing the home care system into line, it found a use for the remnants of the city's anti-poverty program, whose funds

had just about dried up. On the advice of the Vera Institute of Justice, a local anti-poverty think tank, many of these programs were reincarnated as home care employment agencies. Ultimately, 62 nonprofit, community-based organizations became home care vendors. Each now has an annual contract with the city for a specified case load, ranging from 200 to 1,200. The contracts are tightly written and closely supervised by the city's Human Resources Administration. In effect, the agency directors function as contracted middle managers supervising a largely unskilled labor force of 50,000 people.

Caught in the throes of the city's catastrophic fiscal crisis and faced with threats of massive layoffs of its members, even New York's largest and most powerful nonuniform public employees union, District Council 37 of AFSCME, could do little to prevent the privatization of this growing city service. The union did not go beyond uttering the obligatory public outcries. But DC 37 did exact two promises from the city administration for its relative quiescence, one of great potential benefit to the home care workers, and one that threatened to undermine that advantage. First, the administration promised to facilitate wholesale unionization of the new industry. And second, it made an unwritten pledge never to give larger pay increases to contractors' employees than were won by city workers.

While DC 37, fighting to stave off municipal

tji

4;hi

f^~

**Home care worker on picket line.**

bankruptcy, wasn't interested in organizing home care workers who were not public employees, three other unions were. Local 1199, the voluntary hospital and nursing home workers union, Local 32-B and 32-J, primarily a union of apartment house workers, and DC 1707, a smaller social service affiliate of the same AFSCME international as DC 37, had soon organized almost all of the home care workers.

If the development of the home care system was convoluted and complex, the needs of the workers, I discovered, were simple. When the last contract expired on June 30, 1987, most earned less than \$7,000 a year. They had an inadequate hospital insurance plan with no medical, dental, or prescription benefits. They had no job security, no pensions, and were totally isolated from each other. Partly because of the agreement between the city government and DC 37, workers' wages had progressed, at an average rate of 5 percent annually, from minimum wage to \$4.15 an hour. If one of the three unions became a little more assertive on behalf of its members, the city simply picked it off by imposing the least expensive settlement. All three unions had identical wage and benefit packages.

**Finding the Right Allies**

No one said home care workers were adequately paid, but just about everyone argued the impossibility of paying them much more. The critical problem was

to develop a strategy that would make substantial change inevitable. To accomplish this, the Local 1199 leadership needed allies. The most logical allies were the two other unions that represented home care workers.

Although they initially had some doubts about the chances for success, DC 1707's executive director, Bob McEnroe, and its home care director, Josephine Lebeau, readily joined with 1199 to form the New York Labor Union Coalition for Home Care Workers. Together, the unions formulated a set of demands: \$6 an hour, comprehensive family health insurance, pensions, job security, overtime pay, and industrywide seniority. Even more important than the joint demands, each union promised not to settle without the other.

While the unions were natural allies, coalitions, even between similar organizations, are very difficult to sustain. DC 1707, like 1199, styled itself as a progressive union—a champion of left causes and minority politics. This is not the case with Local 32-B and 32-J of the SEIU. The officers of 1199 and 1707 tried through every possible vehicle and intermediary to get the reclusive president of Local 32-B and 32-J, Gus Bovona, to join them, but Bovona rejected all overtures. Lawyers representing him at two meetings with 1199 and 1707 balked at any joint bargaining. At most, they would agree to a position paper spelling out "the problems of the workers."

Lacking a united front, the union coalition decided



Miller Photography

**Most workers were receiving as little as \$4.15 an hour. The new hourly minimum is \$5.90.**

to seek the support of sympathetic local politicians. They first approached Manhattan Borough President David Dinkins. At the time, Dinkins was the only minority member of New York City's Board of Estimate, the upper house of municipal government. Astonished at the size of the industry and the widespread exploitation of its workers, Dinkins organized a public hearing to draw attention to their plight.

The hearing, held in April 1987, was dramatic enough to warrant the notice of New York's major media. The presence of several hundred minority women packed into the board's ornate City Hall chamber, the articulate voices of the workers, coupled with the support of the nonprofit, community-based agencies that employed them and the unions that represented them, made the telling of their plight extremely effective. "The only thing that I am asking for my work is to be respected, to be paid for my job, and to have some kind of services," Gwendolyn Rosemond told Dinkins and other Board of Estimate and City Council members in the crowded hearing room. It was a simple story. Home care workers perform significant, occasionally heroic work, for which they are abysmally paid.

Dinkins summed up his findings in an extensive hearing report: "I found the employment conditions of home health workers unconscionable," he wrote. "As a result of the hearing I am convinced that the present wages, benefits, working conditions and opportunities for advancement of the home care worker must be improved."

Just a month after the hearing, John Cardinal O'Connor and the Rev. Jesse Jackson met to jointly express their support for the workers' cause. While the media led with headlines about the newsmaking get-together of the politically conservative cardinal and the progressive reverend, the fact that the meeting was arranged by the unions and announced their endorsement of the Justice for Home Care Workers Campaign did not go unnoticed in City Hall or the governor's office. Later the same day, Jackson addressed a rally of about 6,000 home care workers and their supporters in front of City Hall. Just about every liberal and minority politician in the city jostled for space on the platform to reiterate his or her support for the workers.

These politicians, however, could not deliver a contract, nor could the nonprofit home care employers. That power lay in the hands of the Koch administration, even though the state's Department of Social Services actually sets the Medicaid reimbursement rates for the home care program and picks up 40 percent of the cost. The city's power lies not in its 10 percent contribution (the federal government pays the other 50 percent), but in its control of all the home care agencies' operations, from contracts to procedural details. Before the nominally independent employer agencies could sign a union contract, the Human Resources Administration, the city's massive welfare and Medicaid agency, had to approve its terms.

Despite the support of Jackson, Dinkins, and the Cardinal, the Koch administration was unwilling to meet the union coalition's demands. According to Koch's chief labor negotiator, Robert W. Linn, the city couldn't commit money for the home care contracts until it settled with the city workers' unions. When that would happen, Linn refused to hazard a guess.

### Developing a Strategy

More than moral high ground and the support of selected politicians was needed to move city and state governments to take the union coalition's demands seriously. Union strategists, led by Dennis Rivera, Local 1199's executive vice president, felt it would be best to negotiate with the home care vendors and then present the contract as a *fait accompli*. With a concrete offer, to which the city and the state would have to respond, the union coalition would be in a better position to gauge the opposition and target its activities.

The coalition laid out its strategy to the most sympathetic of the home care vendors. At their suggestion, the coalition invited the Home Care Council, a trade association, to negotiate on behalf of its members. The council leadership balked, however. Never before had home care vendors entered into negotiations without the blessing and permission of their real bosses—the city's Human Resources Administration, nor did they

feel comfortable negotiating as a group. To allay some of their anxiety and to get the process moving, the coalition agreed to develop a "joint position/" not a contract.

The unions continued to treat the joint position talks as actual negotiations, however. They established a negotiating committee composed of workers from each of the agencies represented by the two unions. The committee laid out its positions and the members debated them. After the usual give and take of contract talks, the two sides arrived at a common position—\$5.90 an hour, significant pay differentials for people who worked 24 hours a day (but were paid for 12) or people working on weekends and holidays, and the establishment of a comprehensive health insurance plan. They deferred agreements on pensions, job security, and overtime pay to the next contract.

The Home Care Council and the union coalition joined together under the unwieldy title of "Justice for Home Care Workers and Recipients." On January 11, 1988, they announced agreement on their "joint position." Simultaneously, they sent letters to the governor and mayor requesting approval and funding for the agreement.

#

*No one said home care workers were adequately paid, but everyone argued the impossibility of paying them more.*

**A member of DC 1707 of the American Federation of State, County, and Municipal Employees.**

Since the joint position was not a contract, neither executive had to reply. And neither did. Instead, each pointed a finger elsewhere. Conveniently forgetting that any agency signing without city scrutiny risked losing its vendor contract, city officials asserted that the issue was between the unions and the employers. The state's position, equally absurd, was that until the city's Human Resources Administration sought approval for new reimbursement rates, the state had no role to play. With both city and state maintaining the posture that someone else had to go first, the campaign was getting nowhere.

A more intensive, sophisticated strategy needed to be developed. The union-management group approached every significant elected official in the city. They sought and received endorsements from Andrew Stein, the City Council president; Harrison Goldin, the city's comptroller; four of the borough presidents; and numerous members of the City Council and the state legislature. But neither Koch nor Cuomo, whose endorsement would carry a commitment to fund the agreement, made public comment.

The coalition convinced a number of city and state

politicians, religious leaders, and "power brokers" to phone the governor and the mayor. Word filtered back that they were now prepared to do something, "details to be worked out." Given the situation of most of the workers, "something" was not enough. The coalition was unwilling to accept anything short of the full agreement.

At one point Bob Linn, the city's chief labor negotiator, told coalition representatives that he would agree to whatever the state was willing to give. Two weeks later he withdrew that promise and offered instead a complicated plan whereby workers would receive an additional 20 cents an hour for each year of service. Linn got so carried away with the coalition's adamant rejection that he forgot who he was talking to. "You are going to drive this industry out of the city," he absurdly charged. Despite a few other off-the-record meetings, the city continued to stonewall.

To move the issue and force a response, the coalition developed a full-scale press campaign. Moe Foner, one of the labor movement's most experienced publicists, went to work, tirelessly convincing major newspapers to take up the crusade. ^

## Home Care: Cooking, Cleaning, and Caring

**B**ack in South Carolina in the 1920s, Pearl Carter's Great Aunt Emma raised her to be independent and to look after herself. "She'd say mother, father, sister, brother, but God bless the child that's got its own." So in the wake of a stroke in 1975, after a lifelong struggle to live on wages from domestic work—"never on welfare, never"—Carter didn't take to the idea of having a home health worker, a stranger, around. When functioning became overwhelming she thought of asking Laura Jones, a friend and former neighbor in her Brooklyn apartment house, to take the job.

Jones said yes—she was tired of domestic and factory work—and so began an enduring relationship that suggests what home health care can be when it is based on deep mutual respect and appreciation.

"I was scared of her at first," Jones says, standing at Carter's bedside one day in July. "I was afraid of sick peoples. She didn't pull no games for a long time and then one day I walked in on her and she was pretending she was dead."

"She was way back to the door, ready to cut out," Carter interjects with glee.

Jones stayed, though she did check for life by shaking Carter's toe. Their 13 years together have spanned important changes in New York's home health care system, which has evolved from a chaotic patchwork of services to a unionized industry involving some 60,000 to 100,000 workers and 60,000 chronically ill and elderly clients. Unions, including Jones' own Local 1199, have recently made gains for home health workers, but at 42, Jones still gets scant wages for her life-giving services.

Today, as always, Jones leaves her home in Brooklyn's Bedford Stuyvesant section around 8 a.m., riding two buses to Carter's apartment in East Flatbush, and wisecracking as she lets herself in. The apartment is hot: no air conditioning, and the windows are stuck closed. While changing into a work dress, Jones tells Carter to check into getting Supplemental Security Income. Every penny counts in this house, where any increases in social security checks are invariably matched by rent hikes, and where \$17 monthly in food stamps doesn't go far. They joke about old times. For two church-going Baptists, women whose dignity is palpable and whose shared

standard is decency, they can get downright raucous.

"Boy, she was big. Fat as a pea," Carter says of Jones, who lost weight after she began as Carter's aide. Carter, a tall woman when she can stand, wrinkles her brow. "She saw me and got shamed. I could not eat. I get up with pain, go to bed with pain."

"I felt embarrassed—I'd have my big plate and she had a roll and coffee," Jones says. Her cooking, if not her eating, has thrived since she started with Carter. "I learned extra dishes I had no business learning from her."

After a good hour's talk, Carter sits in bed with the TV on while Jones sweeps the kitchen with powerful strokes, steps out for bread, and washes out Carter's underwear. They yell back and forth. After a while Jones helps Carter, whose ailments include a blood clot in her leg, arthritis, and poor circulation, plump into her taped-up wheelchair and nudge her feet into worn slippers. Jones gives "Miz Pearl" a bath and breakfast, fixes her hair, and brings her outside for fresh air, where neighbors stop to talk. Jones knows them as well as Carter does.

Often Jones goes out for money orders so she can pay Carter's bills, and they frequently go together to appointments at Downstate Hospital. Carter has spent enough time immobilized in hospitals to know home is best for her. And she, who has done her share of hard work for low pay, is a firm supporter of home care workers' rights. When Jones took time off to rally at City Hall or lobby state legislators in Albany, says Carter earnestly, "what she was saying was the truth."

**F**ridays, Jones cleans and cooks to carry through the weekend, which Carter often spends with her 34-year-old daughter, Julie Luke, and 4-year-old granddaughter, Cassandra. On Saturdays, Jones cleans her own house, and Sundays she attends MacClinton Baptist Church. After 21 years of not being able to afford new curtains, Jones says things are looking up. Her husband has rejoined her after a long separation; her children, Shanice, 18, and Ernest, 20, are finding jobs, and the new pay scale will soon swell her paycheck to \$5.90 an hour.

The raise won't turn her into a high stepper after years of habitual scraping. In fact, "If I

*Leah Halper is a journalist who writes and organizes around Central American health care issues.*

would hit the lottery, if I still be living after the news, I would get some abandoned buildings to fix up and make into housing and a recreation center for people like Miz Carter."

"Don't worry none about the Miz Carters," Carter says. She would open a bus line to Atlantic City for slot machine runs, she boasts from her bed. She hasn't been there since 1985.

Since the lottery is a longshot, Jones is taking night courses to finish high school. She might someday go on to college. At the very least, she'd like more medical training for her work. Frequent agency seminars teach how to bathe bedridden people or deal with heart attacks, she says, but she looks forward to the day that the unions start their own school for home health care workers.

So far the union's effort has brought Jones, who is a diabetic with high blood pressure, better health coverage, the impending raise, and first crack at jobs. A pension is yet to be negotiated,

however, and a recent call to jury duty looms as an alarming loss of income.

Jones and Carter understand that their relationship is unusual in a field where patients' declines and deaths mean frequent turnover. Their intimacy makes coping with emotions difficult when Carter is hurting, says Jones.

"Sometimes I'd just go outside for fifteen, twenty minutes not to see her in pain." Carter, who is usually high-spirited, can get cranky, but Jones has seen crankier. At least Carter's daughter is supportive, whereas Jones dislikes filling in elsewhere on Saturdays because some children mistreat their parents.

In fact, Jones' attachment to Pearl Carter even compels her to rethink that lottery prize.

"I changed my mind," she tells Carter, grinning. "I'd go with you to Hawaii. We'd wear grass skirts and dance awhile, eat pineapples and drink that stuff, coconut juice. Whoo! Look at me now!"  
—Leah Halper

Pearl Carter (left) and Laura Jones.



Kate Breuer



Miller Photography

**Workers hope to win job security, a pension, and overtime in their next contract.**

Foner, a former 1199 officer with great credibility among reporters and editors, was remarkably successful. After a series of sympathetic feature and news stories, the editorial writers waded in. "Nothing's dumber than saving pennies and wasting dollars," the *Daily News* editorialized on March 3, 1988. "Why get tight-fisted with home health care workers,\* who clearly have a strong case for a wage increase? Koch's stinginess could gut the system." The local CBS TV affiliate broadcast a highly sympathetic editorial, "Caring for the Caretakers," which was followed by a *Newsday* editorial declaring: "Stop the games: Penny pinching won't save a dime."

The turning point came on March 14, 1988, when the first of the coalition's ads appeared in the *New York Times* opposite the editorial page where, perhaps serendipitously, the *Times'* editors made their position known. "Can the city and state afford the \$96 million it will cost over the next three years to improve the lot of the home care provider?" they wrote. "If they are truly committed to moving people out of poverty, the answer has to be yes....If they want to enable people

to stay home who otherwise have to enter expensive nursing facilities the answer has to be yes."

Pressured by an avalanche of political and media support, the governor's office began to move. "What do you want?" asked a senior member of Cuomo's staff. "Our agreement with the bosses," Dennis Rivera replied.

### **Victory**

On March 31, a week after the overture, four days after Jackson's victory in the Michigan primary, and 19 days before the New York primary, Cuomo's labor commissioner, Tom Hartnett, worked out an agreement with Rivera and the coalition's chief negotiator, former Lieutenant Governor Basil Paterson.

Despite a price tag of \$350 million spread over two years, Koch told the press he was "pleased." But 12 weeks of often acrimonious negotiations with the city and the vendors followed the March 31 announcement. Having been outflanked by the governor, the Koch administration continued to make trouble. Each time we thought the deal was made, it collapsed over disagreements between the city and state about how much it would cost. Until the city okayed the contract, the agencies wouldn't sign. Once during a discussion in Linn's office, I spent almost an hour arguing with a senior budget official about a penny difference in the cost figures, while Rivera, Paterson, Linn, and an aide watched in silence.

Once the money issues were resolved, each of the unions entered separate formal negotiations with the agencies' management. Allies became adversaries over such issues as paid release time for union delegates, guarantees of a weekend off a month, drug testing, and seniority rights. A full agreement was finally hammered out between Local 1199 and 22 home care agencies. DC 1707 has also completed negotiations, and workers in agencies represented by Local 32-B and 32-J will get the same wage settlement. At a meeting last June, Local 1199 home care workers ratified the contract by a vote of 849 to 9.

### **So Near, Yet So Far**

Two months before the ratification, Local 1199 convened an emergency meeting of the home care workers after a disastrous session with the city. On a hot and humid night, 600 workers packed the union's auditorium on West 43rd Street in Manhattan.

I was standing downstairs when a small, 60ish woman approached me and inquired if I were a lawyer. I told her no, but asked if I could help. She told me she had worked seven days a week for five years because her boss had threatened to fire her if she took a day off. "Is that legal?" she asked.

I went back to the auditorium just as the meeting was ending. That day, April 4, was the twentieth anniversary of the assassination of Martin Luther King. As I elbowed my way through the crowd, someone began to lead the meeting in singing "We Shall Overcome." People linked arms and sang together.

Recalling that harassed worker's question, I thought, we have come so far, but we still have a long, long way to go. •

# 'Ordered to Care!

## Demystifying Nursing's Dilemma

PATRICIA MOCCIA

Nurses are in a bind familiar to all who would nurture in our society, whether they be nurses, teachers, social workers, parents, or friends: How can they care for those in need without sacrificing their sense of self, and how can they care for their selves without sacrificing those in need?

Susan M. Reverby's recent book, *Ordered to Care: The Dilemma of American Nursing, 1850-1945*, helps us to understand the history of that bind. And, although the purposes of such a history do not usually include prescriptions for contemporary problems, Reverby so clearly identifies nursing's central dilemma in her work that it also contributes to discussions on how one of today's health care crises might best be approached. By defining nursing's historical problem as "being ordered to care in a society that refuses to value caring," she raises the possibility that the current shortage of registered nurses requires social reform in addition to, or perhaps even rather than, nursing reform. This by itself throws more light on the issue than practically any of the other, more popular, analyses. It also holds the promise of empowering those who struggle for progressive transformation in health care and society.

Reverby writes about nursing history from 1850 to 1945, during which time the act of caring for the sick changed from a women's duty, to a woman's trade and occupation, to a woman's profession and career. Starting from the experience of nurses working in and around Boston hospitals during that period, she develops an analysis of its national implications. With nursing as a case study, Reverby also provides a much-needed connection between political histories of health care and the hospital system, such as *The Care of Strangers*, by Charles Rosenberg, and *Health Care in America: Essays in Social History*, edited by Reverby and David Rosner; the historiographies of nursing in a patriarchy, such as *Hospitals, Paternalism and the Role of the Nurse*, by Joann Ashley; and analyses of the work culture of nursing, such as *The Physician's Hand*, by Barbara Melosh.

The Nursing Shortage: Whose Side Are You On?

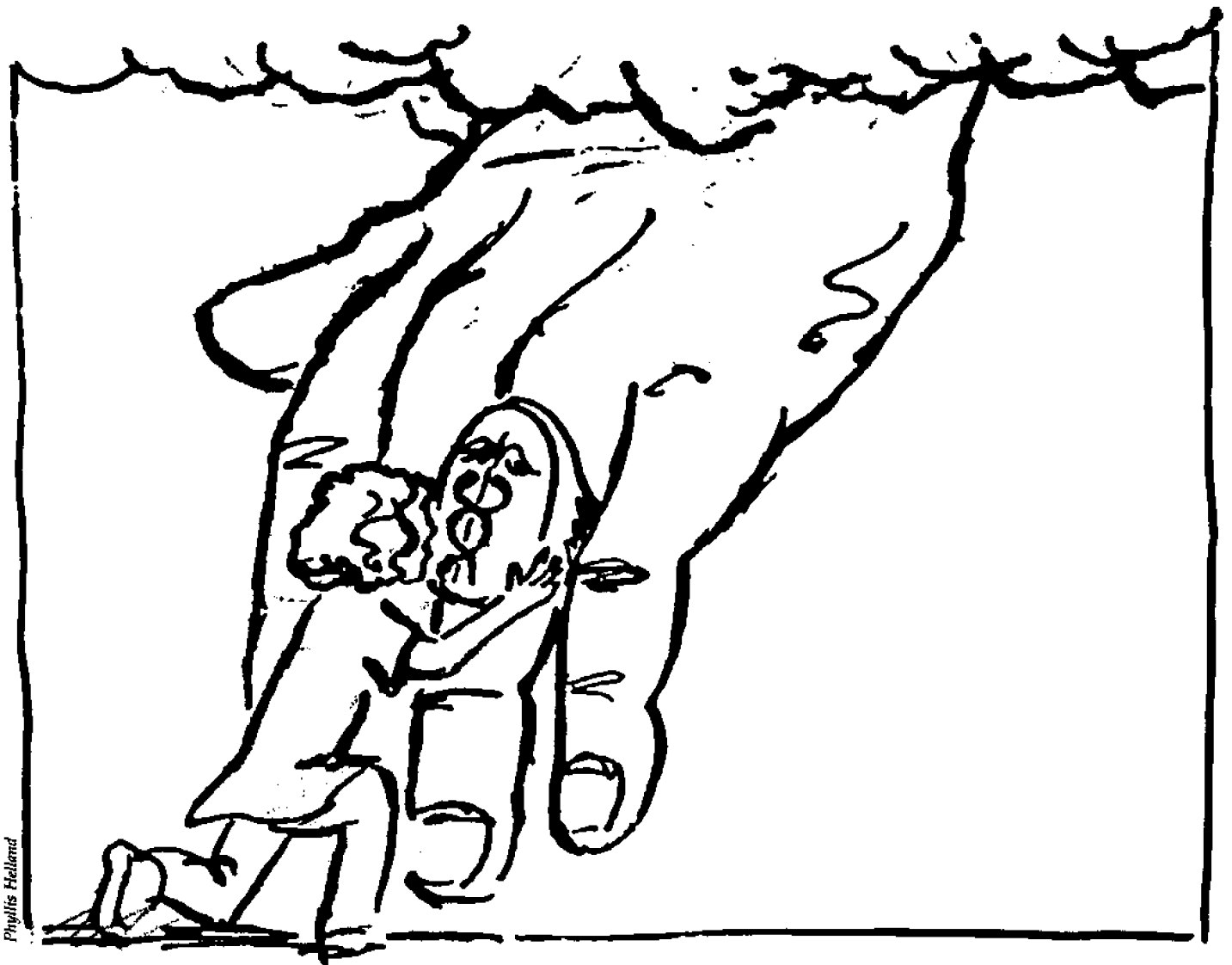
By now, the popular media has convinced all who look or listen that the nursing profession is in the

midst of a crisis of numbers. Nursing positions in almost all the nation's hospitals go unfilled, and nursing schools face declining admissions, enrollments, and graduations. Thousands of dollars are being spent by private foundations such as Commonwealth and Pew to analyze the reasons for nurses' dissatisfaction; by professional and consumer-oriented organizations such as the American Nurses' Association and the National League for Nursing to market nursing as an attractive career option; and by trade associations such as the American Hospital Association to develop strategies to recruit and retain nurses as hospital employees. Even the federal government has finally decided to study the crisis, with a commission appointed by the secretary of health and human services to offer recommendations by the end of 1988.

*From 1850 to 1945, the act of caring for the sick changed from women's duty to a woman's trade and occupation to a woman's profession and career.*

Yet these intensive studies, all by interested parties, are peculiarly limited. They attempt to explain the shortage as the result of particular decisions by individual nurses, would-be nurses, and the nursing leadership. In the context of *Ordered to Care*, this approach seems curiously ignorant of the structural determinants of the problem. Despite the realities of daily life for nurses in hospitals, which Reverby so vividly depicts, serious proposals are still being prepared to find the few nurses who have left intolerable working conditions behind and entice them back to lives of subordination and personal and professional humiliation. Reverby carefully documents the fact that nursing students historically have been recruited from poor and working class families. Nevertheless, some still argue that, as a result of the women's movement,

*Patricia Moccia is a member of the Health/PAC board and Vice President for Accreditation and Education of the National League for Nursing.*



potential nurses are now choosing to study for MBAs or degrees in law and medicine. Yet we know that such programs are still protected by barriers of class and race from the majority of those in nursing's traditional labor pool. Again, Reverby exposes the hospital-based and controlled apprenticeship training that predated the current collegiate programs as a source of cheap and exploited labor, allowing institutions to profit without regard for the quality of nurses' lives either on or off the floors. Yet some still argue for a return to those days and ways in order to assure an adequate labor force for today's hospitals.

These arguments and proposed solutions share several themes. First, they lay the blame for the nursing shortage on nurses themselves: on those who choose not to be humiliated and overworked on a daily basis; on those who might have taken advantage of an opportunity to achieve more autonomy in their daily lives or more money, respect, and security for their families; and on those who have succeeded in moving nursing students away from oppressive training systems toward the relative, albeit limited, autonomy of educational models. In so doing, secondly, these arguments divert attention and responsibility from those

who, like the American Medical Association and the American Hospital Association, benefit from an undereducated, divided, and subservient labor force.

*By crying "nursing shortage/ medicine justifies its latest efforts to dominate and exploit.*

Third, these analyses are critical of what they present as self-interest on the part of nurses and the nursing profession. Nurses, they say, are willing to sacrifice the good of their patients for individual and professional advancement. This assumes, falsely, that the nurse and the nursing profession ever had either the sole responsibility for ensuring care in hospitals or the power to determine how care was to be delivered.

Finally, if heeded, these arguments would put nurses "back in their place" and serve to reinforce and reproduce the authority of those who currently control health.

*Although Reverby's work stops at 1945, attempts by organized medicine to control the education and supply of nurses have not.*

Reverby pulls the veil from these illusions. She identifies nursing's "crucial dilemma." She presents the reader with ample evidence of nurses' struggle with "the dichotomy between the duty and the desire to care for others and the right to control and define their activity." Most significantly, Reverby exposes the root of nursing's problems, those of the health care system, and perhaps even those facing us as a civilization as "the failure of our society to create the conditions under which the desire to care can be valued."

**The Nursing Shortage: Qui Bono?**

Conventional wisdom has it that correctly defining the problem will bring you halfway to the solution. Mileage might be gained, then, by presenting the nursing shortage not as a problem for nurses or for nursing, but rather as a problem for the employer; that is, for hospitals and physicians. Reverby's history tells us that, at least for the years between 1850 and 1945, nurses were clear about what they wanted—a humane system for both patients and employees, one that allowed dignity and integrity and respected the nurse's individuality and autonomy, one that allowed people to care for each other. Today, as economic imperatives become ever more insistent, nurses are clearer and more forceful about what it would take to keep them. Hospitals refuse to hear or to heed. And so we have a nursing shortage.

Or do we? Since more nurses are working now than ever before, the problem seems more one of increased demand than inadequate supply. In other words, it's not that nurses are refusing to work, it's that the hospitals want more of them—both literally and figuratively. The question then becomes: "To do what?"

As a challenge to the currently popular analysis that we are in the midst of a nursing shortage, Dr. Nancy Greenleaf, Dean of the School of Nursing at the University of Southern Maine, has argued that 1.8 million nurses ought to be sufficient to meet the health needs of a nation with a population of about 250 million. She suggests that the roughly 1:150 ratio is only inadequate relative to the needs of a health care system designed for profit, and that the "shortage"

reflects the needs of the employer for more workers, not necessarily the needs of people for more health services. Greenleaf poses two questions that lead to entirely different discussions about the "nursing crisis" and entirely different solutions: "How have the benefits of the nurse supply been distributed?" and, "For whose benefit are those nurses working?"

To read Reverby is to find the answers to these two questions: The nursing supply has been controlled by physicians and hospitals for the benefit of physicians and hospitals. She tells us that in 1878, "The demands of the hospital for a work force often overcame the nursing schools' abilities to educate their students." In 1910, "admissions to nursing schools were determined by hospital needs rather than educational standards."

Between 1920 and the mid-1930s, the growth of hospitals in the United States was dependent on student nurses to adequately staff the institutions. Reverby reveals that although graduate nurses achieved some degree of independence through private duty, the Depression forced them to bow, bitterly, to the pressures of physicians and hospitals and to accept the otherwise unacceptable working conditions offered to staff nurses in return for the security of steady, however meager, income.

*Proposed solutions to the nursing shortage lay the blame on the nurse who chooses not to be humiliated and overworked.*

Although Reverby's work stops at 1945, the attempts by organized medicine to control the education and supply of nurses have not. By crying "nursing shortage," medicine justifies its latest efforts to dominate and exploit. As a recent internal memo of the AMA's board of trustees reveals, organized medicine is so panicked or blinded by self-interest that it can on one hand acknowledge that "nursing has developed professional independence and authority over its own affairs," and on the other presume to interfere in this independent profession by recommending that the AMA set up nursing education programs and methods to accredit them. For these physicians, nurses are neither workers nor independent practitioners, but rather a "critical medical resource" in such short supply that critical care and medical surgical beds are being closed—and profits are being lost—in many parts of the country.

**Nurses' Dilemma, Whose Failure?**

Through this history of American nursing, Reverby makes several points about work, caring activities, and



the position of women in society. Because of a society structured in such a way that human relations are distorted in the interests of efficiency and domination, the activities of nurturing and caring for each other are similarly distorted. As nursing work has traditionally been seen as women's work, its value reflects that of women in a patriarchy. How then can nurses and other women in such a position care for others without caring for themselves?

When nurses engage either of these struggles without engaging the other, and when they engage them alone, their efforts are confused and confusing. Their difficulties in advancing either their own or the patient's interests become the failures of individuals and evidence of the conservative nature of nurses. There is more opportunity for progressive social change when nurses look beyond their boundaries for either analysis or praxis. As Reverby says, "the dilemma of nursing is too tied into the broader problems of gender and class in our society to be solved solely by the political efforts of one occupational group." This re-framing of the nursing crisis is perhaps the greatest contribution of the book.

*Popular arguments divert attention from those who benefit from an under educated, divided, and subservient labor force.*

Though the voices of nurses are missing from this history, Reverby is aware of their value. She acknowledges her debt to nurses Sondra Clark, Nancy Greenleaf, and Karen Wolf for their willingness to share their experience of nursing with an outsider. Her gratitude is also evident in the degree of sensitivity and respect with which she treats her subjects. As nurses increasingly find and use their own progressive voices, they in turn will acknowledge their debt to Susan Reverby for this and other works. •

# The Future of Health/PAC Depends on You



For 20 years, the *Health/PAC Bulletin* has been serving as a guide to concerned people who seek a rationally organized and truly democratic system of health care in this country.

Our readers turn to us for fearless reporting and analysis about the emerging trends that are shaping the way health care is and *isn't* being delivered in this country. The *Bulletin* provides first-hand accounts of what's really happening to health care from patients and providers on the front lines of our troubled health care system.

There are no pharmaceutical ads in these pages, just good, independent writing by people who care about the future of health care, and want to do something about it. If you're not a subscriber, become one. If you are, give or recommend a subscription to someone else. The future of this 20-year-old experiment in progressive health care journalism depends on readers like you.

Yes, I want to become a member of the Health Policy Advisory Center and receive the *Health/PAC Bulletin*.

- Individuals \$35. • Institutional subscription \$45. • Students/ low income \$22.50.
- I'd like to send the *Bulletin* as a gift to the following people. (Please attach names and addresses.) My payment is enclosed. \_\_\_\_\_ Please notify them of my gift.

I want to help Health/PAC support the fight for health care. Enclosed is my tax deductible contribution of \_\_\_\_\_ \$15, \_\_\_\_\_ \$25, \_\_\_\_\_ \$50, \_\_\_\_\_ \$100, \_\_\_\_\_ other.

Name \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip" \_\_\_\_\_

Charge: \_\_\_\_\_ Visa \_\_\_\_\_ Mastercard No \_\_\_\_\_

Expiration Date \_\_\_\_\_ Signature \_\_\_\_\_

Send your check or money order to:  
Health/PAC Bulletin, 17 Murray St., New York, N.Y. 10007

# *Nursing and Caring: Lessons from History*

## *Interview with Susan Reverby*

*The author of **Ordered to Care**, Susan M. Reverby, now associate professor and director of the Women's Studies Program at Wellesley College, was a staff member at Health/PAC from 1970 to 1973. Until then, her only involvement with health care, aside from family dinner conversation (her father is a physician and her mother teaches human biology and medical technology), was a few weeks as a counselor in an abortion clinic. Health/PAC, she says, gave her an instant education. "I learned an enormous amount very, very fast about how the health care system works, about how to be a speaker, about how to think through issues, how to be an organizer, and I'm very grateful." The Bulletin recently asked her to comment on the nursing shortage, nursing history, and her experience with Health/PAC. -Ellen Bilofsky*

Martha Stewart



**Health/PAC:** *You're a historian. How did you get involved with nursing? Did Health/PAC have something to do with it?*

**Reverby:** Yes. I was hired in 1970 because of my interest in the abortion movement. When the person on staff who covered nursing left, it was a natural desk for me to take over, since I was the one with a degree in labor history and an interest in women. And I got fascinated, because I was a historian, by the history. I just fell in love. You couldn't not like them, and you couldn't not be interested in what they tried to do.

Eventually, I left Health/PAC because I was becoming the kind of academic intellectual who needed to have more of a grounding in the complexities of a topic. I was frustrated by what the kind of journalistic writing we were doing required me to do, which was to become an instant expert on some topic I knew nothing about in about three weeks. Frankly, we were often so rhetorical because we were trying to create a movement, and we didn't have the time to be careful sometimes about the complexities of historical change. That's a tension between intellectuals and activists. If you're faced with a problem here and now, you don't have the luxury of trying to figure out the niceties of the past. I felt then, and I certainly feel now, that it also led to a kind of screwed up politics, because if you don't really understand the complexities of the past then you really make political mistakes in the present.

I spent a year after I left Health/PAC trying to decide whether to go on for graduate training in health or whether I wanted to do history, and I decided I didn't want to go to my grave wishing I'd become a historian. So I completed my PhD in American Studies.

*Class so divided nurses historically that gender couldn't unite them.*

**Health/PAC:** *Ordered to Care stops in 1945. Why didn't you bring it up to the present?*

**Reverby:** I knew the end of the story, because at Health/PAC I'd written about what had happened from 1945 on. And also because, like most historians, I made the argument that the seeds of the difficulty had been planted in the early years.

I end by talking about nursing's need to develop a language of rights around caring. I say two sets of things. One is that nurses have to develop a language about rights that doesn't mean just what you individu-



Above, Susan Reverby at her Health/PAC desk in 1973, and (on opposite page) in a 1988 photo taken at Wellesley College.

ally need but what we collectively need— what a communal set of rights would look like for nurses as a group to be able to care properly.

The second is that because the problems of nursing are so tied into the issues of women and of caring more broadly in the culture, nursing cannot solve the problem by itself. The only hope lies in a kind of alliance with other people concerned about what's happening to women and to caring issues in the culture more broadly. There have to be linkages in nursing school programs with women's studies, there have to be links in hospitals and with health consumers and with people concerned about what's going to happen in the hospitals to their loved ones. People have to understand what's wrong with the way the health system is set up now and what's wrong with the way in which nursing has been oppressed.

**Health/PAC:** *Do you consider nurses to be "professionals" rather than "workers"?*

**Reverby:** I think that the dichotimization of profes-

sionals and workers is arcane at this point, at least around nursing. It's an ahistorical question, because whether or not in the objective world you want to label nurses "semiprofessionals" or "workers," in terms of the way they're being educated and in terms of their consciousness, they consider themselves professionals. But what that means may have a worker consciousness to it. I don't mean to suggest that there's not a difference between being an aide and being a nurse. I just think you have to avoid a definition that has some academic sociological and political science meaning. You have to look at what meaning people give to the word themselves. There are different ways to act professionally. There are ways to be professional that also take into account what we would consider traditional worker consciousness. Being a professional does not negate organizing, or caring about anybody else in the hospital. It doesn't have to.

One of the things I tried to say in the book is where the limits of professionalization have been. But that doesn't mean I don't think some of that's important.

I've shifted some ground on the BSN issue over the years. I think that's probably where we went wrong in criticizing nursing when I was at Health/PAC. In 1972 I wrote against the BSN degree as a requirement for entry into nursing practice because the line was that it was anti-working class. Then a friend of mine said to me, "Do you think women shouldn't go to college?" And I thought, what a position for a feminist to take, that women who want to learn something should not go to college!

*There is a cultural crisis in caring, for which women, rather than the structures that created the crisis, are being blamed.*

**Health/PAC:** *But there's a difference between helping women to go to college and requiring a college degree to become a nurse.*

**Reverby:** Right. But there are ways in which you could build ladders in nursing that would give them that. There have to be ways in which college programs are brought to the hospital to give people the kind of broad base that a college education gives.

One of the things I argue in the book is that class so divided nurses historically that gender couldn't unite them. I think that the whole issue of class and race as dividers, as in any women's community, has to be dealt with politically by nurses. We have to acknowledge what it means to help other women move from diploma degrees to BSNs. The health system is only very slowly learning to really value increased clinical skills. We mainly reward people who move *out*, from the bedside into teaching or into administration. But that's true of any kind of service work in this society. At the university we don't reward people for being good teachers, we only reward them if they write a lot of books.

**Health/PAC:** *Then you're suggesting that we reward people adequately just for being good nurses?*

**Reverby:** Oh, absolutely. That's the first step. If nurses' starting salaries were \$40,000 and went up to \$80,000, you'd have no nursing shortage tomorrow. But it's not just money, and that's certainly clear when you talk to nurses. One of the things that's important has to do with what kind of control people have over the job, how they're perceived, whether they're taken seriously as professional colleagues in the hospital. Those issues sometimes speak louder than the money.

**Health/PAC:** *What's creating the nursing shortage? Is there really a shortage?*

**Reverby:** I think it's complicated. I don't follow the current numbers enough to argue whether the bodies are actually missing or not. I think there's what I call a cultural crisis in caring in general, for which women, rather than the structures that created the crisis, are being blamed. We are being blamed for not caring enough, or for not being willing to sacrifice ourselves. The culture has created a crisis in caring by not rewarding caring work in emotional, financial, and status ways. That's causing the crisis, not because women have abandoned their caring role.

**Health/PAC:** *You wrote in one of your Health/PAC articles in 1972 that the "disproportionate number of women [in nursing and other health care positions] reflects the fact that women have few other choices." Well, women now have a lot of other choices. Is that helping to cause the nursing shortage?*

**Reverby:** Oh, sure. I think you'd be naive to not admit that. I'm a health professions advisor at Wellesley, and I've only seen one student who said she wanted to go to nursing school. The problem often is that many students think the only way to make it is to become a corporate vice president, that somehow being a nurse is not something valuable.

**Health/PAC:** *Since nursing has traditionally been a working class profession, are the women who traditionally went into nursing really going into law and medicine?*

**Reverby:** Some. And some are going into banking jobs, real estate, social work. We know that there's a decline in nursing school enrollments. They're going elsewhere. Some. Not all. But that's always been true. Historically, in the twenties lots of women went elsewhere, other than nursing, into secretarial jobs because they paid better.

*Our society will have to really think through what counts as caring.*

**Health/PAC:** *Do you think that bringing in men will help the profession?*

**Reverby:** No, I don't, because I think it's a gendered profession. It's not a question of the bodies and their genitalia in the profession, it's a question of how the culture perceives the work. So more men in it are not going to matter, and in fact more men in it means they just become the administrators. Men tend to rise faster and push faster for the administrative jobs, and they get them. It's the type of work that's an issue, and how the culture links caring work to women's work and assumes it to be natural that women do it.

When the media talks about the shortage, all it does is bemoan the problem, but it doesn't really talk about solutions, or it ends up blaming women for the prob-

lem. The subtext is, "Gee, women shouldn't do this. Women shouldn't be abandoning us. Mommy didn't do it right." Rather than, "Why isn't Mommy doing it?"

**Health/PAC:** *Let's talk about solutions.*

**Reverby:** There ought to be joint education between doctors and nurses. Doctors ought to be required to take an introductory nursing theory course, so that they have some sense of the profession and what its history and demands and needs are. It would help a lot if they knew something about it other than what they see on the hospital floor. There have to be real linkages between women's studies programs and nursing schools. There have to be real linkages between women's groups and organizations of concerned consumers and groups of older people with nursing. If you think about who gets sick, in the end it's older women who are in the hospital. There have to be those kind of linkages. I don't think nursing can do it alone. We all have something to gain. We all get sick and die, every single bloody one of us, and at some point, we're going to come in contact with nursing.

**Health/PAC:** *What about unionization?*

**Reverby:** I think it helps. I don't think it's the only answer. Bread and butter issues are important, but if the unions don't bargain over control of the work process, there are still a lot of problems. Because it isn't just money that's the issue in nursing.

I think a way to go is to increasingly value the nurse clinician and to reward people for increasing clinical skills on the hospital floor. But it will also take giving nurses at all levels more control over their workplace. They need to have a say over pace, scheduling, and what they're allowed to do.

**Health/PAC:** *Can nurses continue to become more specialized and increase their knowledge and their technical skills and still give good bedside care?*

**Reverby:** That's always been the tension. Yes, I think so. I think that it has to be thought through and it has to be rewarded.

**Health/PAC:** *What's your prognosis? Is the nursing shortage going to change the status of the profession?*

**Reverby:** It's actually quite a crucial time for nursing. In the past, medicine has often pushed for an increased division of labor, so that you get more practical nurses, more aides, more technicians. And whether nursing is going to be able to hold on to the need to have more highly educated people, I don't know. The latest AMA language about what they think will be the solution sounds just like what Charles Mayo proposed in 1921. What the AMA proposed is that we should train more "subnurses," in the term Mayo used. Back

to the hospital, technicians, people who come in and all they do is give shots. People to give out meds, as if there was nothing else involved except handing somebody a bunch of pills to swallow. There has to be some long, hard thinking between groups of consumers and nursing leadership and medicine in the hospitals. It's starting to go on, but it's not going on enough yet. And that's why starting by changing some of the thinking in the medical and health administration schools is really crucial.

Otherwise, you'll see the hospital looking more and more like a nursing home; that is, one or two highly trained RNs at the top and then lots and lots and lots of LPNs and aides running it. And I think we will all suffer. It doesn't mean aides and LPNs don't often give very good bedside care. But there's a special knowledge that comes from a broader education that nurses bring as well.

One of the other things we'll probably end up seeing is a real two-class system—a lot of very highly paid technical people on one end and lots and lots of temps, lots and lots of foreign nurses, and lots of confusion in the hospital. And we all have a lot to lose by it.

*Nurses have to develop a language about rights that doesn't mean just what you individually need but what we collectively need.*

**Health/PAC:** *How would health care have to change before nurses could be rewarded for caring?*

**Reverby:** I think our society will have to really think through what counts as caring. We need more studies on how caring and good nursing care really change things that could show how patient recovery is better. But it's going to be a long, difficult, political struggle. It isn't now, nor has it ever been, merely a question of not knowing how to do it. It's about having the political clout to make change.

**Health/PAC:** *Can the highly skilled RNs, the "professionals," can they make alliances with the aides, the temps, the foreign nurses?*

**Reverby:** I think they've got to learn that if they don't they won't survive. That seems to be what the history teaches. •

# *People Power vs. the Almighty Dollar*

## How Democratic Management Can Help Transform the HMO's

HARRY KRULEWITCH

I have spent over ten years working as a physician in democratically managed health care clinics in the Midwest and on the West Coast, and two years working for a large HMO in Minneapolis; in short, I have been exposed to the extremes of health care delivery available in this country.

My experiences in Minnesota have shown me that HMO's have little to do with health, are not interested in illness prevention and health maintenance, and are poorly organized. Their goal is to maximize enrollment and invest profits. I have seen HMO's systematically cut back on health education because it is not immediately profitable, sabotage independent community programs, and avoid any position on critical health care conflicts within the community. I have seen them refuse to either reduce premiums or pay bonuses to physicians at the end of fiscal years in which they reported handsome surpluses.<sup>1</sup>

Many people consider Minneapolis to be the center of the HMO movement. Indeed, our ten HMO's control 41 percent of the health care market in the Twin Cities. Physicians in private practice can also participate in so-called preferred provider organizations (PPO's), in which physicians provide services for reduced fees in return for a steady source of patients. Private physicians in the area depend on referrals from HMO's and PPO's for 60 percent of their practice. Ninety-five percent of all Twin City physicians belong to at least one of these organizations.<sup>2</sup>

It's hard to convey the full impact of this system on our community. Every day our newspapers and television and radio stations deliver a barrage of advertising for HMO's. For-profit hospital systems compete throughout the metropolitan region, and all but one hospital has merged or been sold to one of these national chains. Rural hospitals are closing.

The impact on physicians would have been unimaginable ten years ago. The physician who contracts with an HMO, PPO, or independent practice association (IPA) agrees to let the organization temporarily withhold a portion of his or her fees. Holdbacks for primary care are typically from 10 to 20 percent; specialists must tolerate holdbacks of between 40 and

50 percent. Theoretically, most or all of this money is returned to providers at the end of the year, but if the company did poorly, much of it can vanish with the year-end accounting reports from the central HMO office. In 1986, 40 percent of physicians in the Twin Cities saw their income decline at least 10 percent in this way. Some saw their income cut in half.<sup>3</sup>

### In the Belly of the Beast

How has the HMO system affected me personally? I worked for two years for an HMO organized around a staff model, where physicians are employees. During that time I was often told to do my work and go home and not ask questions about management. I saw physicians presented with 10 to 25 percent salary cuts and was then told that such contract violations constituted an incentive program. During a fiscal quarter when the HMO was running at a deficit, I saw an entire department of nurse practitioners laid off without warning on the day before they were to begin a citywide prevention program, essentially because they were the least organized group of providers. I was told my own pay raise would be withheld because I had organized a meeting of nurses, physicians, and clerical workers to discuss morale. The meeting, I was told, was critical of management and circumvented the standard channels of communication.

There was little flexibility or innovation where I worked, and little understanding of how to run a good clinic or build a health team. Despite a huge number of managers, morale was low and staff turnover high. Physicians felt captive. They had traded control over office and practice for benefits, repayment of their medical school loans, time off, and a secure income. When management began to consider laying off workers and cutting salaries, physicians were unable to organize themselves or confront management directly.

Physicians are recognizing that a transformation is underway. As cost containment fails, premiums rise, and income drops, it becomes apparent that the corporate system is generating huge profits at the expense of both the patient and provider. Some physicians are organizing challenges to the IPA's to question the legality of their management structure and obtain access to their books. Some are investigating the possibility of unionizing. Others are trying to lobby the legislature to pass laws that would enable physicians to engage in collective bargaining without violating antitrust laws.

*Harry Krulewitch, a family physician, worked in participatory health centers from 1969 to 1982. He is currently a fellow in the University of Minnesota's Department of Family Practice and Community Health.*

Many are merging their practices so that solo and small groups are disappearing. Some doctors are dropping out, bitter and frustrated.

No one can say for certain whether for-profit corporations will succeed in taking control of our health care. What's already clear, though, is that the struggle between providers and corporations is transforming a cottage industry into a corporate system. We can debate the quality of care that's resulting, but HMO's are clearly much more effective at managing money and generating profits than the old provider system, and any health planner who does not appreciate this transformation is making a big mistake.

In this struggle over who should control our health care system, only two alternatives are ever presented: providers or corporations.<sup>4,5,6,7</sup> But there is a third choice, although no significant policy currently being put into practice gives any legitimacy to it. The public is capable of and has the right to own and manage its own health care resources, and it is this alternative that we must fight for.

#### Health and Empowerment

It was my experience, in 11 years of work in participatory systems, that democratic ownership and participation can encourage community members to make fundamentally different choices about the use of their health care resources. I have seen democratic groups use resources for education, prevention services, home care, and community economic development, to establish neighborhood councils, and even to support a local nursing strike. The combination of personal self-care, community self-reliance, and worker

self-determination can turn a health clinic into an agent for social change.

*The goal of HMO's is to maximize enrollment and invest profits.*

Democratic ownership is a complex issue, and dear to me personally. Despite its failures and problems, democratic management was the structure that most helped me to change my idea about what good care is and how a management system determines the quality of care. Collective work helped me to develop skills in communicating, sharing, listening, and cooperating. I learned to respect the contributions of others, and I could then apply those skills when working with patients. I continue to provide traditional clinical skills and diagnoses, but by using even a few learning skills and promoting a few prevention concepts, I can begin to change my role as a physician. I find the transition from authority to facilitator personally rewarding.

In the late 1970's I worked in a community-owned, worker-managed clinic in Oregon, which delivered integrated, holistic care. There, rather than making decisions for patients and controlling the course of their visits, the staff spent time educating them. By validating their concerns, exploring what physical,

nutritional, socioeconomic, and emotional factors were involved in their illnesses, and which of these they could be responsible for, we attempted to empower them. We helped patients use cooperative skills—respect, communication—in interacting with their families, teaching them the power of those skills to affect their health and, ultimately, their community. In this way family medicine can be a model for larger social change.

Prevention services and self-care advocacy were important allies in this process: we supplemented our care with an outreach program to local communities and business. We formed a Health Action Council to bring health issues to the attention of local government. We trained block workers in leadership and self-care, devising procedures through which these workers could represent their communities in raising issues with the clinic's board.

#### Surviving the Lean Years

Of course, the maintenance of our democratically controlled clinic took an incredible amount of energy from its members. As the clinic grew more successful, democratic management became more and more difficult. When professionals were brought in to provide some business skills, conflicts arose between them and the original members, from whom they had very different values and perceptions of the role of management. Had we been able to orient the newcomers to our style of democratic management, we might have been able to work things out. Instead, the conflicts, coupled with cuts in funding, led to the clinic's eventual decline.

### *Democratic health systems need to be nurtured through unions, citizens' groups, and legislation.*

I see now that any democratic group that wishes to survive needs to commit itself to ongoing analysis of economic and political conditions. I have seen other democratically managed systems dissolve under the complexity of today's sophisticated health care delivery system, unable to make fiscal projections or coordinate complex billing reimbursements. The inability to accept clear lines of authority and establish effective business plans has destroyed them. But more than the lack of skilled fiscal and technical managers, the inability of people to cooperate and work for each other became insurmountable during difficult financial times.

The bottom line for the health planner, and particularly one who supports democratic control, is: Will the care be better in a democratic system? When the patient goes out the door of a clinic in our democratic

health system, will she or he have had better medical care?

#### Redefining the Doctor's Role

The physician has a crucial role in answering these questions. At the heart of the medical system is the interaction between two people: patient and provider. The quality of that interaction is how we will measure that system; beyond any bureaucratic reorganization or national policy, it is in that setting that our efforts will be judged. That interaction, in workplace and in examining room, can be the place where we begin to create a new model of health care. Will it be oppressive or liberating? Insensitive or compassionate?

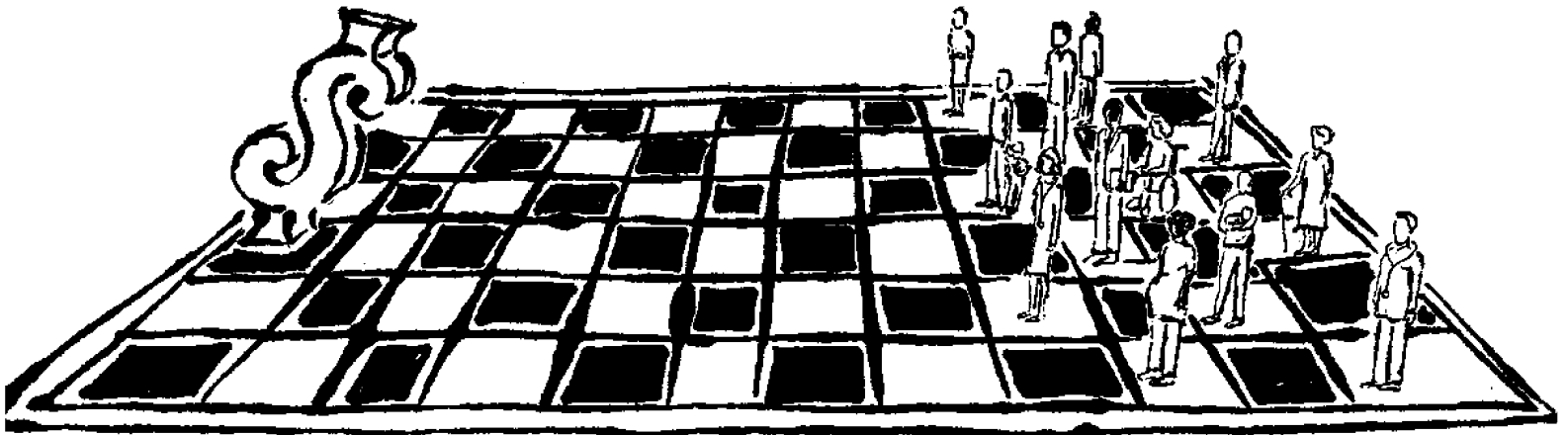
### *Some doctors are dropping out, bitter and frustrated.*

Today, the doctor-patient relationship is forged in our medical schools and residency centers, where the training is highly structured and extremely rigid. Doctors train in multimillion dollar institutions amidst great poverty and suffering. The work is hard, often violent, chaotic, depressing, and frustrating. The glaring contradictions involved force many physicians to set their own survival above anything else. Distrust, isolation, cynicism, and arrogance are rampant. The authority physicians are taught to assume helps them remain insulated from their surroundings during these difficult years, but leaves them incapable of working in a cooperative setting. Physicians trained in such traditional systems are not likely to be interested in sharing control with patients. Where trust, intuition, communication, and caring are not valued, physicians are unlikely to empower others through their efforts to heal.

Democratic systems create new problems. The physician's is not a rotating position that is easily shared. Patients expect and need continuity of service. Yet physicians in democratic management systems face hostility from their professional peers and animosity from their own co-workers still dealing with repressed anger from previous encounters. The challenge is to build a system that can allow physicians to retain their proper sphere of responsibility without leaving them or others in the system unaccountable.

#### Change from Within

There are great obstacles to building any system of democratic ownership or management. These include the powerful, who will fight for the perpetuation of their privilege and profits; the complexity of the system itself, with its numerous reimbursement, therapeutic, and management modalities; and the communities that feel threatened when cultural standards are questioned by democratic initiatives and



Phyllis Helland

consequently will not give their support to them. Most of all, though, the obstacles lie within us, because we have little skill in nurturing or cooperating with and trusting each other.

But as public dissatisfaction with corporate medicine grows, as physician-patient interaction is reduced to a product-and-sales approach, patients will realize that their physicians have also lost control. There will be more opportunity for change. That change could be democratically driven, or it might come through massive federal reform, or worse, through support for greater subsidy of the privatization of the industry.

I do not know how we will get to a democratic system. But there is a lesson to be learned from dance therapy: support precedes movement. Democratic strategies need to be nurtured at many different levels, and in many regions, through citizens' groups, unions, coalitions, networks, and legislation. We need health providers, health planners, managers, and administrators who have studied and worked in well-organized research centers dedicated to studying the issue of democratic control. University and graduate schools need to develop programs around such a curriculum, and we need working models to challenge our imagination.

Physicians need to justify their leadership by

promoting alliances with their patients and the communities they serve, not by fighting for a return to the days of provider control, and not by accepting corporate control as the only other option. The kinds of physicians who will do that are most likely to come from those communities that have encouraged democratic programs to grow. If democratic health systems are to evolve, they will emerge from personal, local, and regional efforts that give credibility to the idea of public ownership of resources. •

1. Miller, M. "Minnesota Health Care Markets: Cost Containment and Other Public Policy Goals," *1984 Report to Legislature, Minnesota Department of Health*. Reported in the *Minneapolis Star and Tribune*, 11/28/84, Section IB.
2. *Reece Report*, Vol. 1, No. 3, June/July 1986, p. 11.
3. *Ibid.*, Vol. 1, No. 2, May 1986, p. 6.
4. Murray, J. "A Comparison of Patient Satisfaction Among Prepaid and Fee for Service Patients," *The Journal of Family Practice*, February 1987, p. 203.
5. Kennedy, L. "The Losses in Profits—How Proprietaries Affect Public and Voluntary Hospitals," *Health/PAC Bulletin*, Vol. 15, No. 6, Nov./Dec. 1984, p. 5.
6. "Medical Discord: Some Doctors Assail Quality of Treatment Provided by HMO's," *The Wall Street Journal*, Vol. 67, No. 235, 9/10/86, p. 1.
7. "Doctors Will Review HMO's Effect on Care," *Minnesota Medical Association Annual Report*, 1986. Reported in the *Minneapolis Star and Tribune*, 5/3/86, Section IB.

# South Africa's Reign of Terror

MERVYN SUSSER

*Since 1982 South African destabilization efforts had an increasingly devastating effect on the health of the Mozambican people. The displacement of millions of people and the deliberate destruction of health facilities has caused immeasurable suffering and the loss of hundreds of thousands of lives, mostly of children. ...By Dec. 1987 an estimated 4,500,000 people of the total population of 14,000,000 were in need of urgent food aid owing to the combined effects of war, displacement and natural disasters. The primary health care system built up so successfully over the years since independence was under attack."*

These words by A.R. Noormahomed and Julie Cliff introduced a detailed 1987 report from the Mozambican Ministry of Health on the destruction wrought in Mozambique by the forces of Renamo, an organization renounced even by the Reagan administration. Renamo is a South African cats-paw, one aspect of a program to create a military firebreak at the borders. Perhaps more important, the program aims to destroy any model of social and political development that might inspire or build confidence in black South Africans.

Health and social services personnel are a primary target, in a manner learned, directly or indirectly, from the CIA in Central America. Under the program, South African proxies lead "civil wars" in the region, making use of assassination — witness the killing of the ANC's Dulcie September in Paris; the killing of others in Lesotho, Botswana, Swaziland, Zimbabwe, Zambia, Angola, and London; and the near death, by car-bombing, of ANC attorney Albie Sachs in Mozambique.

External terror is the twin of internal desperation. The country is on the rack; repression is tightening. South Africa has by now assured its leading place as the most severe censor in the world of news and information. Naturally, all this is reflected in health and social affairs. For example, last March, Ivan Toms — known for his

heroic job of creating primary care in the Crossroads shantytown outside Capetown, before the authorities bulldozed it — was given a 21-month prison sentence for refusing to serve in the armed forces. Of course, the armed forces are now the agents of internal as well as external oppression.

At Baragwanath Hospital, the largest hospital for blacks in the country, 101 doctors who protested on be-

ANC lawyer Albie Sachs following bomb attack by South African agents.



Alfredo Bucche/Impact Visuals

*Mervyn Susser is Sergievsky Professor of Epidemiology at Columbia University and Director of its Gertrude H. Sergievsky Center. He is a co-founder of the Committee for Health in Southern Africa.*



An armed policeman arrests a student during an anti-apartheid protest at the University of Cape Town.

half of their patients were reprimanded and required to apologize on pain of dismissal. "Facilities are completely inadequate. Many patients have no beds and sleep on the floor at night and sit on chairs during the day," physicians wrote in the March 1988 newsletter of the National Medical and Dental Association. "The overcrowding is horrendous," they continued. "Ethical standards are undoubtedly compromised."

As social and political conditions deteriorate under repression, no relief is to be expected for the deplorable health conditions. The South African Department of National Health and Population itself reported that in 1987 more than one-third of rural black children under the age of 5 were malnourished (1.8 percent wasted, 25.4 percent stunted, 8.4 percent low in weight for their age). Yet we should take heart. Despite all, the struggle for a post-apartheid state continues.

Readers of the *Bulletin* should be reminded that their protests are heard and responded to by both the oppressors and the oppressed. Evidently the authorities were reluctant to bring Ivan Toms to trial because he was known abroad. And the 40 or more doctors at Baragwanath Hospital who did not apologize have not been dismissed; the issue is apparently being papered over. After a firestorm of outrage abroad, the proportion of children under 18 who are among those detained without

trial has declined. Children accounted for approximately 40 percent of an estimated 10,000 people who were held after the emergency was declared in June of 1986; according to the *New York Times*, children now account for about 10 percent of the 3,000 people still in detention. In the intensely protested matter of the Sharpeville Six, who were sentenced to death for guilt by association in the killing of a suspected collaborator, the judge uncharacteristically stayed the execution. All of these developments owe much to international protest. But we must not let up. Besides the manifest inequities in health, torture by the security police, already well documented, continues.

The South African government — still not put at arm's length by the Reagan administration — has much to hide. It should come as no surprise that the members of a delegation to South Africa sponsored by the Association for the Advancement of Science, the Institute of Medicine, the American Psychiatric Association, and the American Public Health Association were denied visas on the day they had proposed to leave. The group had intended to examine the effect of the law and the emergency on health services for the population, including those in detention. For the regime in Pretoria, the message to a concerned world continues to be that the malignity beneath the stones is not to be revealed.D

## ***Pro-Choice for Teens Endangered***

Is "family communication" promoted when a young woman must obtain the legal consent of her parents if she wants an abortion? This is the asserted goal of parental consent or notification laws, which exist in various forms in 25 states and restrict access to abortion for women under the age of 18.

This summer, a federal appeals court upheld a Minnesota law requiring women under 18 to obtain parental or judicial consent before having an abortion. A similar law was struck down in Ohio.

Though such laws are considered constitutional only if they include a judicial bypass (an alternative and intimidating procedure in which minors must go to court to circumvent their parents' veto), they not only invade the woman's privacy, but they increase the risks to her health by complicating, lengthening, and slowing down the process of getting an abortion.

Proponents of these laws overlook the mental health implications of compelling teens to secure parental consent or making it all but impossible for young women to end unwanted pregnancies. The push for consent laws is taking place against a national background in which one out of nine pregnant women under age 20 receives little or no prenatal care, thus decreasing the chances of the baby's surviving its first year of life.

As one might expect, the laws are frustrating but otherwise failing to deter teenagers from seeking abortions. Many teens face the added burden of crossing state lines to get abortions, points out Asta Kenney, a policy analyst at the Guttmacher Institute in Washington. According to Randy Frank, Director of Development at the National Abortion Rights Action League in New York, parental consent laws are meant "to intimidate teenagers and clog up the court system."

^  
|  
^  
|^  
£ The presidential election has focused attention on a flurry of activity concerning abortion rights. The right wing has exhumed another related "family" issue: spousal consent. Ruled unconstitutional and

put to rest 12 years ago, it has now risen from the ashes. In a Bush-ruled America, a husband might go to court to seek custody of the unborn fetus of a wife who desires an abortion.

Is spousal consent merely another attention-grabbing variation on an old theme, or do we have good reason to worry? Though Randy Frank of NARAL dismisses spousal consent as a "hot media issue, a ridiculous talk-show issue," she recognizes the precariousness of the situation.

"We're afraid to bring these issues to the Supreme Court," Frank says. While newly appointed Justice Anthony Kennedy has yet to rule on abortion, he has upheld a law that gave money to religious groups to advise young girls against it. The four justices who have been pro-choice in the past are all about to retire or die, and a Republican victory in the fall could further alter the balance. • —Anna Reisman

## ***Good News At Last from the NLRB***

A proposed ruling by the National Labor Relations Board on appropriate bargaining units for health care workers has the potential for revitalizing union organizing efforts that have become bogged down in the labor board's bureaucracy.

Until now, the board has had no fixed policy on which groups had to be included when health care workers attempted to unionize. Instead, the board decided the issue for each organizing drive on a case-by-case basis. For example, nurses' aides who wanted to join a union would not know ahead of time whether they might also be required to organize and bargain for all the LPN's and dietary technicians in their hospital, or perhaps would have to add the maintenance and clerical workers to their bargaining unit. Obviously, the necessity of signing up such large and disparate groups of workers, along with the inability of organizers to plan their campaigns in advance, put a damper on unionizing efforts. (See "Foxes in the Henhouse," *Health/PAC Bulletin*, Vol. 18, No. 2.)

The current version of the proposed rules, expected to be promulgated sometime this fall, sets up eight different categories of bargaining units, with separate units for registered nurses, physicians, and all other professional employees, as well as for technical employees, skilled maintenance workers, business office clericals, guards, and other nonprofessional employees. Once approved, the rules will apply to all pending cases, although unions may still petition for combined units. Labor leaders anticipate that many new organizing opportunities will open up as a result of this decision.

What led the board to open the issue of bargaining units for rule-making? Embarrassment, says Gerry Shea, head of the Health Care Division of the Service Employees International Union. "Even the Reagan appointees on the board became acutely embarrassed about the inability of the board to operate with any continuity," he explained.

The new rules represent an enormous victory for health care workers following years of litigation over each organizing attempt, according to Bob Muehlenkamp, director of organizing for the National Hospital Union/1199. "The facts were on our side. This decision fits the workers' conditions," he said. "How strong our case must have been for the Reagan-dominated board to hand us the whole decision!" •

—Ellen Bilofsky

## ***The RCTFlap: Nurses Fight AMA***

A recent membership-approved proposal by the American Medical Association once again pits nurses against doctors in a power struggle over patient care. The ostensible issue is how to fill the nation's 300,000 vacant nursing slots. The AMA proposal calls for legions of MD-supervised "technologists" to provide routine bedside care. The American Nurses' Association has charged that the proposal shows "an appalling lack of concern for consumer safety."

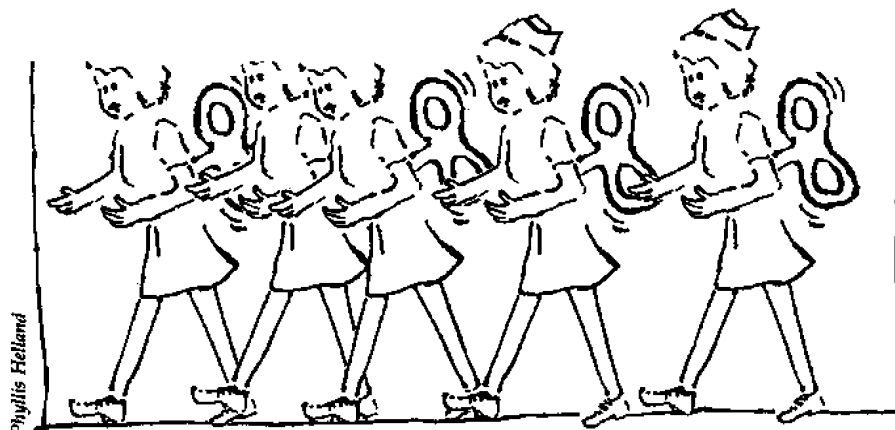
Minimally trained "registered care technologists," high school grad-

uates with 2 to 18 months of training, would be hired to perform such duties as taking temperatures, changing bed pans, and administering some medications under supervision.

Unlike nurses aides and licensed practical nurses, who currently perform these tasks under the supervision of registered nurses, the RCT's would be registered and certified by the state medical boards. "This profession is not going to tolerate not having people at the bedsides to take care of their patients," said AMA Executive Vice-President Dr. James H. Sammons.

The plan follows the long medical tradition of attempting to divide and conquer the hospital work force. "Adding a new kind of worker would be costly and further fragment health care delivery," said an ANA spokesperson. The ANA and other nursing organizations argue that higher pay and improved working conditions, including relief from administrative tasks, are the best way to alleviate the nursing shortage. •

—Tammy Pittman



Phyllis Feldman

# Watching Washington

## Recycling: A Sane Approach To Garbage

Barbara Berney

**T**he trouble with garbage is that you can't get rid of it. In its unsorted form, nobody wants it. You can bury it in landfills, but sooner or later it leaks out and poisons the water. You can burn it, but that releases emissions and leaves a residue of ash. Some of those emissions poison the air; the ash can be buried, but sooner or later it leaks out and poisons the water. Garbage, like other matter, cannot be destroyed, only transformed. We can either purposefully recycle it into useful products, or bury it now and be forced to deal with it later when its toxic components find their way into the water, air, or soil.

For the last two decades, Americans have dealt with their garbage mostly by burying it. Now all our landfills are either filling up or have turned into Superfund sites. (Under the Superfund legislation, the EPA is required to identify hazardous waste sites and clean them up.) During the next seven years, 50 percent of these will be forced to close. Already, in the Northeast and other parts of the country, no new sites are available. In many places where potential sites exist, the NIMBY phenomenon — "not in my backyard" — precludes their use. After all, we pay taxes or private hauling fees to get our own garbage out of our backyards. We certainly don't want other people's brought in.

So municipalities are turning to the burning option — incineration. Incinerators appeal to local govern-

ment as the obvious high-tech, low-change solution. With incinerators, garbage trucks still haul the same trash to the same site; the only difference is where they put it when they get there.

Despite their high cost and capital requirements, incinerators are appealing to cities because much of their cost is hidden from casual inspection and comes from sources other than the local budget. Their construction is often financed with tax-exempt bonds, transferring costs to the federal taxpayer. People who pay electricity bills pick up part of the price tag when their utility purchases the energy an incinerator generates, sometimes at inflated prices. Some costs are covered by the hikes in garbage-hauling fees that inevitably occur if everything doesn't go as promised — and with incinerators, it generally doesn't. Costs end up being higher than expected, energy production lower. Plants get shut down for expensive repairs while garbage must be handled elsewhere. A trash-to-steam plant in Tuscaloosa, Ala., which opened in 1984, lost \$3 million in its first three years of operation. A plant in Tampa, Fla., lost \$6 million in 1986.

Incinerators come in a variety of sizes and models. Most are now designed to produce energy — either as heat or as electricity — and so are called "resource recovery operations." All have two things in common: they all spew toxins into the air (called "fly ash") and they all generate waste residue that must be disposed of ("bottom ash"). The poisons include dioxins, of Agent Orange and Love Canal fame; lead, cadmium, and other heavy metals; acid gases; particulates; carbon monoxide; and PCB's.

Exactly what and how much is emitted by a given incinerator depends on the content and temperature of the burning garbage and on the devices the plant uses to control air pollution. Some, such as the one opened recently in Alexandria, Va., have virtually none. There are, in fact, no federal regulations requiring the use of pollution-control equipment by incinerators, nor are most of the toxins that incinerators produce regulated under the Clean Air Act.



Phyllis Hellard

Even if incinerators were required to install scrubbers and other devices to trap fly ash instead of releasing it into the air, the problem of disposing of it would remain. Ry ash is quite toxic; whenever it's been tested, in fact, it has qualified as a hazardous waste. The EPA has nevertheless determined that it can be mixed with bottom ash and safely disposed of as municipal waste — sent back to the dump, in other words, to start life as garbage again.

### *You Can Go Home Again*

So if it's no good to bury garbage or burn it, what else can we do? Produce less of it (that's called "source reduction") and reuse it ("recycling"). First of all, let's look at what's in garbage. The composition of a representative sample of American trash is as follows: paper and paperboard, 37 percent; yard waste, 18 percent; glass, 10 percent; metals, 10 percent; food waste, 8 percent; plastics, 7 percent; other components, 10 percent.

Much of this material is easily recovered. Glass can be ground up, shipped back to glassmakers, and reused. Aluminum and steel can be melted down and reused. Newsprint and corrugated cardboard can be made back into pulp and reused. Clean white office paper can also be pulped and made into paper again. Yard wastes can be composted and used as fertilizer or mulch. That takes care of 60 percent of the waste, and it's the easy stuff to recycle. Programs already implemented in a number of cities have netted a 15 to 35 percent reduction in waste.

Not only does recycling reduce the amount of waste that must be discarded, it saves a great deal of energy — more than that produced by incinerators. Using recycled materials for paper production, for example, consumes 60 percent less energy than using virgin materials; the savings in glass production is 25 percent. Burning a pound of paper generates 500 BTU's of steam; recycling it saves 2,000 BTU's.

Methods are being rapidly developed for recycling plastics as well. The best solution, though, would be

to ban most plastic packaging, the volume of which increased 40 percent from 1980 to 1985. We once managed with paper grocery bags, and Europeans use string bags. We were able to get milk home before the invention of the plastic jug. Many localities have already restricted the use of plastic containers.

Packaging in all its forms represents 35 to 50 percent of the waste we produce and its volume has increased 80 percent since 1960; it is an excellent candidate for source reduction. Perhaps if everyone left excess packaging on the checkout counter, retailers and manufacturers would get the idea. Removing plastics and metals from incinerated garbage also cuts emissions of toxic organic compounds and heavy metals.

Lawn wastes, which compose up to 30 percent of the waste in large cities during fall and spring, could be shredded in place and given back to homeowners for use as compost or mulch. Imagine a city saving money for itself and its citizens at the same time.

Some countries in Africa — Mozambique, for example — suffer from severe paper shortages. Perhaps the Agency for International Development could provide pulpers, machines that turn paper back into pulp and then into paper again, through a sister-city, or even sister-school, program, while offices could provide the necessary raw material — used white paper and corrugated cardboard. Wastepaper is already New York's leading export by volume. Perhaps our garbage can help cut the trade gap.

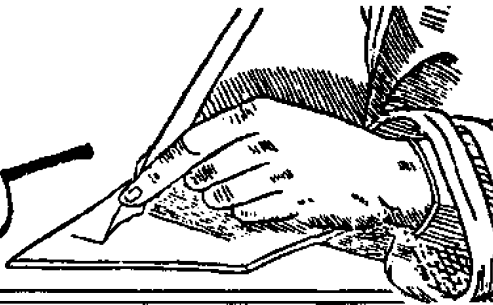
While some incinerators work hand in hand with recycling, most require a guaranteed flow of garbage to be cost-efficient and so preclude such reuse. Some also need plastics and paper in order to burn hot enough to operate properly. If the United States actually constructs the more than 200 incinerators planned for the next four years, we will have lost an important opportunity to make recycling and source reduction a major part of the solution to the current garbage crisis. Many years may go by, and much air and water may get poisoned, before such a chance presents itself again.

City officials tend to worry that

recycling, which requires some participation from everyone, would be difficult to carry out, anger voters, and provoke opposition — in short, that it would prove a logistical and political nightmare. Grassroots action now can force them to recalculate this algebra of waste. The current crisis represents an important opportunity for immediate and long-term public education about the impact of decisions about production on our life, our health, and our community. It also provides the chance to raise our awareness of the consequences of our choices about what we consume and how we dispose of the by-products of our consumption.D

*Barbara Berney is a consultant on health care and occupational health in Washington, D.C.*

# Peer Review



## Poor Funding for Indian Health

It was with great interest that I read the article by Joshua Lipsman on the continuing crisis at the Pine Ridge reservation (Vol. 18, No. 2). My experience from 1983 to 1986 as a family practitioner on the Gila River Indian Reservation (one year as clinical director) confirms the frustrations that Dr. Lipsman has documented. Although the problems that I encountered were not quite as severe, I also had to deal with an aging facility (constructed in 1941 with additions made with trailers) and a very ill, constantly growing indigent population. We were also severely understaffed and actually experienced the loss of our full-time diabetologist while I was there (in a community where type II diabetes affects 50 percent of the people over 30). In spite of all this, I counted myself lucky to have not been stationed in the Aberdeen Area, where conditions were so poor that the IHS had diffi-

culty retaining physicians even for one-year tours of duty. At a national conference of clinical directors, I heard stories even worse than those related by Dr. Lipsman.

In 1986, an effort was made by the IHS to address the serious deficiencies in funding and staffing, but after a few years this effort appears to have run out of steam. The new facility that Dr. Lipsman is waiting to see constructed has been repeatedly sidelined. I fear that it may happen again if funding is not assured prior to the next election.

The problems that Pine Ridge has been experiencing are part and parcel of what the entire Aberdeen Area of the IHS has had to deal with over the past 20 years. This is to be contrasted with the relatively well-funded operations in the newer hospitals in the Albuquerque, Phoenix, Navajo, and Alaska Areas. The innovative programs of Zuni mentioned in Bill Deresiewicz's article are only possible because the basic medical needs (emergency and acute care) of the

*The editors welcome letters from readers. Letters should be typewritten and double-spaced, and are subject to editing for clarity and space.*

community are being met in a new, well-staffed and well-funded hospital. That such inequities should occur within the IHS is a result of confused and irrational funding and priorities as set by Congress.

Funding for various regions of the IHS has been traditionally directed according to the political clout of a region's congressmen/women rather than according to any rational needs assessment. Some way must be found to insure the federal government's adequate funding of the IHS and to distribute it according to need. If Congress fulfilled its obligations to Wall Street the way it does those to Native Americans, the U.S. would have become bankrupt long ago. Our financial obligation to

provide for adequate health care for American Indians should be taken just as seriously as that of paying interest on Treasury bills. To do otherwise is as irresponsible as it is immoral.  
JOSEPH LURIO, MD  
Bronx, NY

### Are You Moving?

**Please send both your old mailing label and your new address to: the Health/Pac Bulletin, 17 Murray Street, New York, NY 10007.**

### Statement of Ownership, Management and Circulation (required by 39 S.S.C. 3685)

*The Health/PAC Bulletin*, publication number 179051, is published four times per year in the spring, summer, fall and winter. Subscriptions are \$35 per year for individuals, \$45 for institutions. Mailing address: 17 Murray Street, New York, NY 10007. Owner and Publisher: Health Policy Advisory Center at the same address. Executive Editor: Joe Gordon, at the same address.

	Average no. copies each issue during preceding 12 months	Actual no. of copies of single issue nearest filing date
Total no. copies	2925	2600
Paid circulation		
1. sales through dealers	224	222
2. mail subscription	2074	1954
Total paid circulation	2298	2176
Free distribution	45	55
Copies not distributed	582	369
Return from news agents	0	0
Total	2925	2600



Timothy McCarrthy

**We congratulate the Home Health Care workers who fought so hard for our contract victory.**

**w. thank all our friends who aided the struggle.**

**w extend solidarity to Home Health Care Workers fighting for Union recognition.**

**And we Pledge to continue the struggle until full**

**JUSTICE IS WON**

**wi cam, wi COUNT.**

**DCfTOT**

**Bettye Roberts**  
President

**Robert McEnroe**  
Executive Director

**Odessa Powell**  
President, Home Care Local 389

**District Council 1707, AFSCME, AFLCIO**

**Q** E S ^ B ^ B Drug, Hospital & Health  
l j S l v f l % m care Employees' Union  
H U H RWDSU/AFL-CIO

# **IN UNITY & SOLIDARITY**

with  
**Home Care Workers  
Everywhere**



# IN SOLIDARITY

## THE COMMITTEE OF INTERNS AND RESIDENTS OF NEW YORK, NEW JERSEY AND WASHINGTON, D.G

*Founded 1957*

ROBERT SCHWARTZ, M.D.  
*President*

JONATHAN HOUSE, M.D.  
*Executive Director*

ROBERT BOORSTEIN, M.D.  
*First Vice-President*

SHELLY FALIK, M.D.  
*Secretary-Treasury*

ERIC LARSEN, M.D.  
*Second Vice-President*

DAVID KERRISON, M.D.  
*Third Vice-President*

MARTHA MASO, M.D.  
*Officer-at-Large*

JOSEPH SACHTER, M.D.  
*Officer-at-Large*



386 PARK AVENUE SOUTH  
NEW YORK, NY 10016  
UNION OFFICE: 725-5500

*Once again, HEALTH/PAC focuses attention on an issue of vital importance to all who care and struggle for appropriate health services for anyone and everyone in need.*

*We salute you.*

**DISTRICT COUNCIL 37, AFSCME, AFL-CIO**

Frank Morelli, *President*   Arthur Tibaldi, *Treasurer*  
Elaine Espeut, *Secretary*   Stanley Hill, *Executive Director*  
Martin Lubin, *Associate Director*

**Executive Board:**

Donald Afflick  
James Butler  
Albert Diop  
Andrew Holman  
Bessie Jamison  
Eliot Reif  
Shiekie Snyder

Louis G. Albano  
James Carosella  
Charles Ensley  
Charles Hughes  
Ruth Levine  
Robert Schmidt  
Jessica Williams

Francine Autovino  
Tom DiNardo  
Victor Guadalupe  
Sylvia Hutchins  
Vincent Parisi  
Edward Simon  
Reginald Wing



George Cohen

# THESE ISSUES ARE STILL HOT

Back issues of the *Health/PAC Bulletin* are available for \$5 each (\$12 for institutional subscribers), postage paid. To order, send your name, address, the issue(s) desired and your check or money order to:

**Health/PAC Back Issues**  
17 Murray Street  
New York, NY 10007

Visa and MasterCard will be accepted for orders of \$15 or more. Please be sure to include the full account number and expiration date.



*vol. 17, #6*  
Rethinking a national health program: three views  
War attacks health in Nicaragua  
Radium dial painters' brush with justice



*Vol. 17, #4*  
**Special Issue on South Africa**  
Interview with the President of NAMDA  
The story of a South African Nurse  
The Karks' community-health innovations  
U.S. health-related corporations in South Africa



*vol. w, m*  
**Special Issue on AIDS**  
Grassroots minority groups fighting AIDS  
Interview with a man with AIDS-related complex  
A social worker's story  
Critique of *And the Band Played On*

*ft v \**  
Lji/PAQBI

**PLAIDS,**  
NOTJWKSTOJOU  
MR REAGAN

*Vol. 18, #2*  
**Assessing the Reagan Years**  
Health policy under Reagan  
Countering arguments against a national health program  
The limits of incrementalism

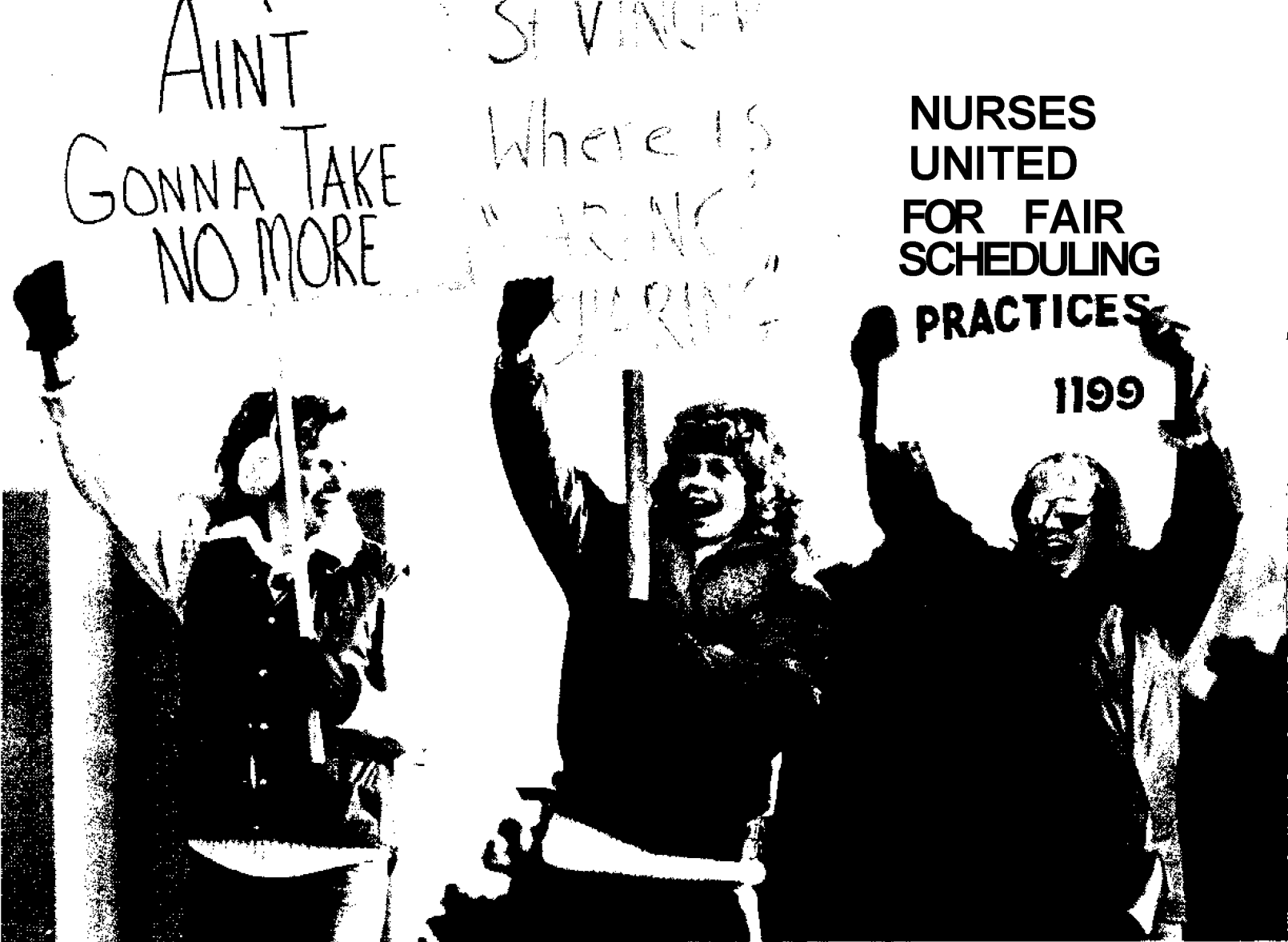
*m 16, #6*  
**Women's Health Issues**  
Baby Doe debate  
Assessing the prejudice against mid-life childbearing  
The cervical cap: test case for U.S. regulatory policies

*Vol. 17, #m*  
How Prospective Payment is transforming hospital care (Part 1 of 3 on PPS)  
Health care under fire: interview with Dr. Myrna Cunningham of Nicaragua  
Public health roulette in Nevada

*Vol. 17, 02*  
How the Reagan administration failed on AIDS  
Quality-of-care problems under Prospective Payment (Part 2 of 3 on PPS)  
The crack scare

*Vol. 17, #3*  
"Health care is sick in St. Louis": the privatization of a city's system  
Professional Review Organizations and Prospective Payment  
Massachusetts' successful referendum on national health

*Vol. 17, 06*  
The fight over MASSCARE  
Labor's safety and health movement  
Anatomy of a national health program  
Anti-quackery legislation



**Inside:** *Transforming the HMO's* page 24  
*Nursing's dilemma: Review of 'Ordered to Card* page 15  
*Interview with Susan Reverby on nursing* page 20

Health Policy Advisory Center  
17 Murray Street  
New York, New York 10007

2nd Class Postage  
Paid at New York, NY.

NOTE TO SUBSCRIBERS: If your mailing label says 8705, your subscription expires with this issue.