

Does Collaborative Bargaining Make a Difference in Nursing Agreements?

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Abstract

This paper analyzed contract language from twenty-two collective bargaining units between nurses and Michigan hospitals to determine if the use of a collaborative bargaining style led to better contract outcomes for nurses. Language on two issues articulated by nurses as important to them were examined: (1) autonomy and voice, (2) mandatory overtime. The results showed a difference between collaboratively and competitively bargained contracts in two areas. One was that interest-based contracts are less likely to specify particular solutions to certain issues such as overtime and are more likely to include language on problem solving processes. The other is that cooperatively bargained agreements are more likely to include language that flags overuse of overtime or temporary workers and a mechanism for referring the problem to a joint problem solving body.

Introduction

This paper examines traditionally and cooperatively bargained agreements between twenty-two Michigan hospitals and the Michigan Nurses Association (MNA). Each contract was analyzed for differences between these two types of bargaining in addressing problems facing the nursing profession. Successfully addressing nursing concerns is important because of the implications of the current nursing shortage for the quality of patient care. The twenty-two hospitals account for three-quarters of the organized hospitals in Michigan. The agreements discussed here are those currently in force.

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The Nursing Shortage

According to the Bureau of Labor Statistics (2002), registered nursing will be among the top 10 in growth of job vacancies. The average age of registered nurses is 41.9 years, which indicates that the shortage can be expected to worsen as the current cohort retires and younger workers are drawn to other occupations (Buerhaus et al. 2000). Although there are long-term structural reasons for the nursing shortage, more readily addressed contributors include workload, physical demands of the job, mandatory overtime, and lack of autonomy and opportunity to participate in decision making (Clark et al. 2001).

Faced with this shortage, hospitals are searching for ways to attract and retain nurses. Cost containment has made wage increases infeasible for most hospitals (Schumacher 2001). One approach to address the nonpecuniary concerns of nurses is that used by magnet hospitals. Recognition as a magnet hospital signals "excellence in nursing, services, development of a professional milieu . . . and growth and development of the nursing staff" (Havens 2001:258). This summarizes what nurses have articulated as primary concerns: respect for the nursing profession and concern for patient care.

Distributive versus Integrative Bargaining

The two approaches to collective bargaining are traditional and integrative (or interest based or mutual gains). Traditional bargaining is based on an adversarial relationship between the parties and focuses on competing for resources or authority in a zero-sum context. Mutual-gains bargaining is based on the premise that the parties have mutual interests and that the best and most durable agreement is built on that commonality. Key features of interest-based bargaining are mutual respect, consensus decision making, and the valuation of the relationship between the parties. The hallmark of interest-based collective bargaining agreements is the recognition of the expertise of the workforce and employee participation in decision making.

One would expect interest-based bargaining to more successfully address nursing concerns than a traditional approach. Both hospitals and nurses share a concern for quality of patient care, providing a basis for mutual-interest bargaining. Integrative bargaining requires mutual respect from both parties and a high valuation of their relationship. In this paper, we compare contracts generated by both bargaining processes to determine whether interest-based bargained language better meets the needs of nurses.

Analysis of Contract Language

Although interest-based bargaining has been in use since the 1970s, it is employed in only four of the twenty-two Michigan hospitals organized by MNA,

a considerably lower proportion than in manufacturing in Michigan (Cutcher-Gershenfeld et al. 1996). The four hospitals are Sparrow Hospital, the Regents of the University of Michigan, Marquette General Hospital, and Herrick Health Systems. Language on two issues articulated by nurses in both types of contracts is examined here: (1) autonomy and voice and (2) mandatory overtime.

Autonomy and Voice

Voice is articulated in cooperatively bargained contracts by acknowledging mutual interest, expressing respect for nursing expertise, and inclusion of joint decision-making processes. All of the contracts, regardless of bargaining approach, include language acknowledging nursing expertise and its role in providing care. The cooperatively bargained contracts, however, also provide for joint decision making, shared authority, and trust during both the bargaining process and the life of the contract. The University of Michigan contract spells out the trust the university has in its workforce:

It is our collective belief that treating professionals utilizing professional guidelines and principles results in accountable behavior. It is our desire to continue to function . . . expecting professional and responsible behavior. As professionals, you deserve to be treated as professionals and [this contract is] intended to be responsive to that. (Addendum B, p. A-3)

Article 63 in the Sparrow Hospital agreement commits both parties to consensus decision-making and problem-solving flexibility by creating a mutual-gains committee:

[Both parties recognize] the common goal of providing quality patient care . . . [and] that employees should participate in decisions affecting delivery of patient care and related terms and conditions of employment . . . and have a mutual interest in developing delivery systems which will provide quality care The parties have established the following mechanisms for the discussion and good faith consideration of these issues The Employer and PECSH/MNA agree to continue participation in joint learning on collaborative relationships. (Article 63, p. 105)

This clause acknowledges that key staffing and care-delivery decisions should be made jointly and indicates a commitment to using and improving cooperative decision making.

The Lenawee Health Alliance contract emphasizes the mutual interest of both parties in protecting the integrity of the hospital and quality of patient care:

The Association and the Alliance are committed to a business partner philosophy. We pledge to work as partners and share a responsibility to make decisions that are in the best interest of all parties To this end, we are committed to working as partners and recognize the value of service provided involvement, empowerment, open book management, open communication, and effective listening.

Although this language does not include the term “interest based,” it does specify tools commonly used in cooperative negotiations such as open communication and effective listening.

The agreement with Marquette General Hospital, Inc., commits to interest-based bargaining in its “Purpose and Intent” clause. After stating the parties’ mutual interest in quality of care, the paragraph concludes,

To such desirable ends, the Hospital and the Association encourage to the fullest degree, harmonious and cooperative relationships between their respective representatives at all levels, and among all employees.

The management rights clauses in the cooperatively bargained contracts also contain language differentiating them from traditional contracts by specifying a joint decision-making process or referring to sections of the contract that describe consensus decision making. For example, the Marquette agreement contains the following management rights clause:

The parties also recognize that the Hospital can best fulfill its staffing needs by encouraging and inviting the full cooperation of the professional registered nurse To this end, the parties agree that staffing and related subjects can best be discussed within the framework . . . as provided in Article 14.0—Nursing Communication System. (Article 2, Section 2.5, p. 3)

Article 14 specifies that all problems presented to the Professional Nursing Committee will be made by consensus decision making (Article 14, Section 14.3 [a], p. 30).

This contrasts with more traditional language such as that in the Hackley Hospital contract that makes it clear that final decisions and points omitted from the contract are subject to managerial discretion. That contract states,

To achieve these ends the Association recognizes that it must respect the proper functions of Management and allow the maximum free-

dom to manage consistent with the terms and provisions of this Agreement, and that the enumeration of management functions herein does not exclude other functions of management not mentioned below. (Article III, Section 3.1[a], p. 8)

Mandatory Overtime

Mandatory overtime is controversial because of its effect on the quality of nursing work life and its consequences for the quality of patient care. Hospitals have been trying to operate with fewer nurses as a cost-cutting measure by using mandatory overtime. In response to the nursing shortage, however, hospitals have begun to find ways to minimize the use of mandatory overtime. Both traditional and mutual-gains contracts recognize that overtime is unavoidable. The primary tools used to reduce mandatory overtime for bargaining unit members include flexible scheduling, in-house float pools, and use of nonbargaining-unit temporary or per diem nurses. One form of flexible scheduling is allowing full-time regular nurses to work either 8- or 12-hour shifts. The language on shift length varies little depending on bargaining approach: all four of the cooperatively bargained, and all but two of the traditionally bargained, contracts allow for this.

Another form of flexible scheduling is part-time work. All of the agreements include regular part-time nurses in the bargaining unit. If hospitals were trying to use the availability part-time work as a way to attract and retain nurses, one would expect the benefits and terms of employment to be comparable to those of full time, but this is not the case. Although there are differences across contracts in the level of benefits offered to part-time workers, these differences do not vary by bargaining approach, and health insurance benefits for part-time workers are not substantially better for those working under a mutual-gains contract. Two of the cooperatively bargained contracts provide for health insurance identical to full-time workers, but so do four of the traditional contracts. Another four traditional contracts provide the equivalent to full-time benefits if a minimum number of hours are worked. The other two cooperative contracts require part-time workers to pay more for their health care than full time.

There is the same absence of a pattern in other types of benefits. Seven contracts stipulate dental insurance benefits equal to those of full-time workers, two of which are cooperative bargaining hospitals. All of the contracts provide for pro-rated pension benefits, and all provide for pro-rated paid time off, although three contracts, two of which are mutual-gains contracts, further limit paid time off for part-time workers.

Hospitals also use nontraditional staffing to deal with mandatory overtime. The two forms of this are (1) the use of employees who are members of the bargaining unit who have scheduled hours and float from unit to unit on an

as-needed basis and (2) contingent use of nonbargaining-unit nurses who may or may not be employees of the hospital who work on an as-need basis for irregularly scheduled hours or to fill in for vacations, absences, and so forth. Contingent work is a complex issue for unions. Nonbargaining-unit nurses can be an attractive source of labor when there is a staffing need that bargaining unit nurses do not want to fill; however, overreliance on contingent nurses threatens a long-term loss of work for the bargaining unit.

The use of float or supplemental pool workers who are members of the bargaining unit typically does not pose serious problems for unions. The distinction between float and regular employees is the variability in their work assignments. Typically, assignment to float status is voluntary, and the employee accrues seniority in a specific unit. Seven contracts analyzed here have this arrangement. Three are with hospitals that bargained cooperatively, which suggests that hospitals that use cooperative bargaining are more likely to rely in internal pools as a source of staffing flexibility.

In addition to the float/pool arrangement is the use of relief/per diem or temporary nurses. Relief/per diem nurses can be but are not always employees of the hospital. If they are employees, they typically have a minimum number of hours they are expected to work, but those hours are not regularly scheduled. Three contracts specify that arrangement, one of which is in a mutual-gains contract. Temporary workers are typically used to substitute for a longer period than per diem or relief workers, such as during a vacation, pregnancy leave, or temporary vacancy. These are more troubling for unions, because of the potential threat to the integrity of the bargaining unit by routinely placing work with nonunion employees. All but six of the contracts have some reference to the use of temporary workers, including three of the four cooperatively bargained contracts.

Both types of contracts contain language that protects the bargaining unit against erosion by the use of contingent worker. This may be a statement in the contract that temporary nurses will not be used to erode the bargaining unit, such as that in the Community Memorial Hospital contract, which states, "The hospital agrees that the use of such personnel shall not be for the purpose of substantially eroding the bargaining unit" (Article 1, page 2). Twelve of the thirteen contracts that specify the use of contingent nurses also contain a clause about protecting the integrity of the bargaining unit. The other sort of protection is language limiting the time a temporary worker can be used before having to join the bargaining unit. The limits range from 28 days to 6 months. As is the case with the language governing benefits for part-time workers, there is considerable variation across contract but no clear pattern with respect to bargaining style. On the basis of the contract language, it appears that hospitals that use mutual-gains bargaining are slightly more likely

to rely on internal flexible staffing arrangements that do not threaten the union. This is a qualified conclusion, however, because several of the traditionally bargained contracts contain similar language.

One area where interest-based contracts sharply contrast with traditional contracts is in the overall language governing overtime. Traditional language unambiguously specifies that it is a right of management to schedule overtime. An example of this type of language is in the contract with Allegan General Hospital, which states,

There shall be no limitation on the Employer's right to schedule or require reasonable amounts of overtime work. (Article XXVII, Section 4, p. 61)

Integratively bargained contract language specifies joint processes for addressing situations where mandatory overtime becomes too onerous. For example, the University of Michigan contract lays out a process for examining the use of overtime:

The parties agree that . . . some overtime is unavoidable . . . [however] these occurrences of overtime shall be monitored and addressed according to the following procedures. (Article XV, Section E, paragraph 163, p. 40)

The language then describes the "overtime trigger," which flags when overtime hours exceed 5 percent of regularly scheduled hours over a four-week period. The Workload Review Committee then reviews the unit and makes recommendations.

The Sparrow Hospital contract decentralizes the overtime decision by authorizing each unit to devise its own overtime schedule but includes language to assure that overtime does not become a regular staffing solution:

Any time a unit's total overtime and worked on-call on any shift exceeds 7% for two consecutive periods, a meeting will be initiated between [the union] and management to determine if there is a need for additional positions/personnel. (Article 46, Section 46.1, p. 76)

A letter of understanding in the Marquette General Hospital candidly stated that mandatory overtime continues to be a problem and no single solution could be incorporated into the contract:

The parties discussed various options of how to minimize [mandatory overtime] The parties agree, however, that they could not

arrive at a one size fits all solution for all units Accordingly, the parties agree that each unit . . . should evaluate their current processes for scheduling . . . with a view towards determining whether reasonable alternatives can be . . . implemented. (Letter of Understanding: Standby, p. 70)

Conclusion

A comparison of the two types of contracts shows some similarities. Both provide for differing day lengths for full-time workers and use of part-time workers, with no clear difference in the generosity of fringe benefits for part-time workers. There is some difference by bargaining style in how hospitals use float or pool nurses, but the language in both types of contracts allows for the use of temporary or per diem workers.

The two types of contracts differ substantially in two areas. One is that interest-based contracts include far more language on problem solving processes. The other is that traditionally bargained contracts articulate a presumption that the hospital has unilateral authority to resolve any problems not covered by the agreement, whereas interest-based contracts contain an explicit or implicit recognition that such issues will be jointly resolved. Further, cooperatively bargained agreements are more likely to include language that flags overuse of overtime or temporary workers and a mechanism for referring the problem to a joint problem solving body. This sort of flexibility is one mechanism for assuring nursing staff of a voice in both the structure of their own work lives and in their ability to balance work demands with a concern for quality of patient care.

References

- Buerhaus, Peter, Douglas Staiger, & David Auerbach. 2000. "Implications of an Aging Registered Nurse Workforce." *Journal of the American Medical Association*, Vol. 283, no. 32 (June), pp. 2848–954.
- Bureau of Labor Statistics. 2002. *Occupational Outlook Handbook*. Washington, DC: U.S. Department of Labor [<http://stats.bls.gov/oco/ocos083.htm>].
- Clark, Paul, Darlene Clark, David Day, and Dennis Shea. 2001. "Healthcare Reform and the Workplace Experience of Nurses." *Industrial and Labor Relations Review*, Vol. 55, no. 1 (October), pp. 133–48.
- Cutcher-Gershenfeld, Joel, Patrick McHugh, and Donald Power. 1996. "Collective Bargaining in Small Firms." *Industrial & Labor Relations Review*, Vol. 49, no. 2 (January), pp. 195–212.
- Havens, Donna. 2002. "Comparing Nursing Infrastructure and Outcomes: ANCC Magnet and Non-Magnet CNE's Report." *Nursing Economics*, Vol. 19, no. 6 (November/December), pp. 258–66.
- Schumacher, Edward. 2001. "The Earnings and Employment of Nurses in an Era of Cost Containment." *Industrial and Labor Relations Review*, Vol. 55, no. 1 (October), pp. 116–32.