Union-Management Negotiations over Nurse Staffing Issues in Hospitals

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Abstract

Over the past several decades, systematic understaffing in hospitals under the pressures of managed care and mergers has led to a diminution of job satisfaction and morale among nurses and, even more critically, has had an adverse impact on patient outcomes. In reaction, unions have attempted legislatively to enact bans or limits on mandatory overtime. Some unions as well have sought to enact statutes setting staffing levels based on patient mix and acuity. In this paper, the authors, utilizing as a database Michigan contracts, have assessed the relative success of unions in limiting the discretionary authority of management over staffing in such areas as layoffs, floating, limitations on nursing duties, staffing of units, and assignment of overtime. Although unions have had some success at the bargaining table, the results indicate the significance of continued union efforts to achieve improvements in working conditions through legislation

Over the past decade, the metamorphosis of health care institutions under the pressure of managed care and mergers has precipitated a dramatically negative effect on the working conditions of nurses. In many hospitals, efforts to reduce costs are achieved by reducing the number of nurses, increasing workloads, and expanding the responsibilities of nurses. With reduced manpower, nurses have been required to work increased amounts of overtime and float across multiple units and multiple specialties (Greiner 1996; Shindul-Rothschild et al. 1996). The systematic understaffing within hospitals has led

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to a diminution of job satisfaction and morale among nurses and more critically has had an adverse impact on patient outcomes (Aiken et al. 2001; Feldman Group 2001; Peter D. Hart Research Associates 2001).

Unions have attempted to ameliorate the adverse working conditions confronting their memberships and the nursing profession in general in a number of ways. Most unions in the health-care industry have supported legislation to ban or limit mandatory overtime. Some, like the Service Employees International Union (SEIU), have also endorsed efforts to legislate minimum manning levels. To date six states—Maine, Maryland, Minnesota, New Jersey, Oregon, and Washington—have passed legislation restricting mandatory overtime, and California has recently enacted a statute setting staffing levels that is based on patient mix and acuity.

Unions have also resorted to the grievance arbitration process as a means to challenge and reverse staffing levels that are viewed as unsafe (Wolkinson and Lundy 2001). A third approach involves union efforts to address the issue of understaffing through the collective-bargaining process. On the one hand, unions can place constraints on management decision making. Where unions possess sufficient bargaining power, they may seek to place specific limitations on management's discretionary authority over staffing. Alternatively, with the development of cooperative labor-management relations, unions and employers may seek to address issues of quality of care and staffing through joint committees in a manner that ideally meets the employer's competitive concerns and employees' needs (Holley and Jennings 1984).

To date, there has been little effort to examine the degree to which unions have been able to affect staffing outcomes through the collective-bargaining process. This paper attempts to fill this void by looking at the experience of unions that represent nurses in the state of Michigan. Through the cooperation of Michigan locals affiliated with the American Nurses Association, the SEIU, AFSCME, AFT, and UAN, the authors have identified 62 hospitals in which unions represent nurses for purposes of collective bargaining. In particular contract language pertaining to staffing, management rights, seniority, layoff, overtime, and joint labor-management committees has been evaluated to identify the degree to which they have succeeded in negotiating limitations on management's authority over staffing.

Restrictions on Layoff

Where unions possess substantial bargaining power, they may be able to successfully negotiate contractual provisions restricting management's capacity to lay off nurses. An agreement between the Presbyterian Hospital and the New York State Nurses Association is illustrative:

> An employee hired before January 1, 1993, shall not be laid off during the terms of this agreement. An employee hired in a bargaining position before January 1, 1998, shall not be subject to layoff during the term of this agreement, except in the event of closure of beds for longer than three months, or reduction in the total number of inpatient discharges/outpatient visits in the affected unit for period of no less than 45 consecutive days.

Note that this layoff restriction is absolute for those hired before January 1, 1993. For nurses hired after that date, layoffs are permitted, but only if beds are closed or there is a prolonged reduction occupancy. In such a circumstance, the hospital retains some flexibility to adjust staffing levels in accordance with patient census.

In Michigan, contracts rarely reflect a union's capacity to restrict layoffs. In only one of the 62 agreements was management's capacity to lay off qualified. In this one case, management could lay off only if the patient census fell below 150. The general protection afforded unions, found in 53 (85 percent) contracts, is the requirement that management lay off in reverse order of seniority. In 35 agreements (56 percent), the employer was required to lay off others, such as temporary and part-time employees before laying off full-time nurses. In 19 (31 percent) contracts, management made a commitment to work with the union prior to implementing any layoffs. Typically this involves union-management discussions over the scope and nature of employee bumping rights that might be occasioned by any layoffs (Table 1).

TABLE 1
Layoff Issues

Issue	Number of Cases (62 total)	Percentage
Management must lay off others before laying off full-time nurses	35	56
Layoffs in reverse order of seniority	53	85
Senior nurses are allowed to take layoff	3	5
Management must first seek volunteers	7	11
Seniority is not listed as a dimension	3	5
Management will work with the union prior to layoff	19	31
Management capacity to layoff restricted	1	1.6

Contract Staffing Provisions

At the same time, it is important to consider that a no-layoff guarantee does not ensure adequate staffing levels. Nor does it address issues concerning the floating of nurses into the departments in which they may not have the requisite qualifications or the requirement that nurses perform duties outside the scope of traditional nursing practice. In Table 2, we examine bargaining outcomes on these matters.

In the 62 contracts, there are just two cases where there the agreement is silent on staffing. In light of management's reserve rights, it is likely that management would have nearly unlimited discretion in these cases when making staffing decisions. In the remaining 60 cases, the contracts incorporate a management-rights provision affording the employer the authority to determine staffing levels or the number of employees, subject, however, to specific contractual limitations. Significantly, in an additional 39 units (63%), the employer exercised broad authority to determine staffing levels subject to its responsibility to consider the input of nurses and/or eschew imposing excessive work loads on nurses. In only nine cases (14%) were unions successful in negotiat-

TABLE 2
Staffing Issues

Issue	Number of Contracts with Language (62 total)	Percentage (rounded to the nearest whole)
Management has right to determine staffing levels or numbers of employees	60	97
Management determines staffing but will consider nurse recommendations and/or seek to avoid excessive work demands	39	63
Meeting or committee structure to resolve staffing issues	22	35
Staffing is based on patient acuity levels, nurse-patient ratios, or staff mix in specific units/jobs	9	14
Restrictions on floating (nurses will not float unless they have needed transferable skills, qualifications, or necessary training)	12	19
Limits on nursing duties	32	52
Silent on issue	2	3

ing specific staffing levels based on patient acuity levels or nurse-patient ratios, either for the entire hospital or for specific units or jobs. The infrequency with which mandated staffing ratios are negotiated is likely the result of stiff management opposition that is grounded in concern over costs as well as the difficulties in sustaining specific manning levels in a labor marker marked by nursing shortages.

Restrictions on Nursing Duties

Unions were most successful in obtaining language that limits work assignments, achieving this outcome in 32 (52 percent) of the contracts. One subset of contracts essentially limits work functions to those "independent and dependent" functions identified as falling within the scope of recognized nursing practice, although some of these included language extending a nurse's professional responsibility for total patient care treatment if the situation necessitated additional interventions or emergencies arose. A second group specifically exempts nursing staff from performing clerical or housekeeping duties. Here, too, exemptions are extended for specific "reasonable situations" or cases of emergencies.

Floating

In 12 (19 percent) of the agreements, specific language was negotiated restricting the floating of nurses across recognized nursing units or functions for which nurses are not adequately trained. One agreement enabled union members to provide input into any changes to the employer's float protocol, including designation of personnel, duty assignments, and competency requirements. Two contracts had specific language mandating orientation to new units for floating nurses, one of which also required training for any nurses unfamiliar with an assignment.

Joint Committees on Staffing

Joint union-management committees have been established where the parties believe that, for certain problems, cooperative effort can generate mutually beneficial outcomes. These committees may provide an alternative to the extremes of management exercising exclusive authority over staffing levels or the union contractually dictating nurse-patient staffing ratios. At the same time, management's willingness to share decision-making authority over staffing with the union as a result of joint union-management discussions is not a common occurrence in Michigan. In 22 (35 percent) of the units, the contract establishes a union-management committee for the purpose of addressing staffing issues. Yet in only four of them do the agreements explicitly require the endorsement of both parties before any changes in staffing could become effective.

One such contract was between Sparrow Hospital and the Michigan Nurses Association, which contains the following language:

> The willingness of the parties to reach these understandings has led to the creation of the Mutual Gains Committee . . . . All decisions regarding significant workplace restructuring which directly affect employees shall be reached through a consensus process between the Employer and the Union. When a consensus is reached, the changes agreed to will be implemented only after ratification by a simple majority of the employees in the affected unit.

Restrictions on Overtime

Of the 62 contracts surveyed, 61 incorporate management-rights clauses affording the hospital the authority to assign overtime. Absent restraining language, the employer is empowered to do so. In 53 of these 61 units, unions succeeded in negotiating some provision affecting the manner in which overtime is allocated, separable into two broad groups. The first, covering 21 units, encompasses situations where the employer can select employees for mandatory overtime, but must first seek volunteers. In many of these cases, management would also be required to assign overtime to the least senior employee. In a second group of cases, involving approximately 21 other bargaining units, unions have been successful in placing more vigorous constraints on the hospital's authority to mandate overtime work. These include actual restrictions on the amount of overtime employees can work. Other limitations include provisions that nurses working 12–hour shifts or who are otherwise not scheduled to work shall not be required to work overtime. In view of these bargaining outcomes, it is apparent that in most units management retains authority to mandate overtime work.

TABLE 3
Overtime Contract Provisions

Provision	Number of Contracts (62 total)	Percentage
Management-rights clause affords hospital authority to assign overtime	61	98
One or more specific restrictions	53	85
Management can assign overtime but must first seek volunteers	21	34
More serious restrictions on management's authority to assign overtime	21	34

Some Concluding Observations

In a large recent American Nurses Association survey, approximately 72 percent of nurses indicated that "not satisfied" best described their feelings as they left work (Cornerstone Communications Group 2001). This prevailing sense of dissatisfaction over working conditions is significantly related to concerns over inadequate staffing, long hours, and perceptions that workers have inadequate opportunities to participate in policy decisions affecting their working conditions. To the degree unions can persuade workers that they can effectively address these concerns through the collective-bargaining process, unions will have a powerful tool in organizing nurses.

At the same time, the survey of Michigan contracts demonstrates that, for at least one major industrialized state, unions have achieved only limited success in addressing staffing issues through collective bargaining. Few if any unions are able to restrict management authority to lay off employees. While many employers will seek union input in determining staffing, most have reserved for themselves the authority to set staffing levels. Similarly, although union-management committees on staffing serve to institutionalize practices and procedures for sharing information and addressing problems, the ultimate authority on staffing typically rests with management. The pattern of dominant management authority is also reflected in contractual provisions on overtime with unions restricting management authority to mandate overtime work in only 21 (34 percent) of the bargaining units. These outcomes underlie the significance of continued union efforts to achieve improvements in working conditions through the process of legislative enactment.

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