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Pay Equity in Minnesota: State and Local Wage Policy Innovation

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Comparable worth emerged in the 1970s as a controversial innovation for public employers. This new wage policy seeks to remedy the historically low salaries for jobs traditionally associated with women and minorities. In Minnesota, the policy is called *pay equity* to emphasize its goal of wage fairness. With the passage of the 1982 State Employees Pay Equity Act, Minnesota became a leader in such wage innovation. The funding and distribution of pay equity raises between 1983 and 1987 has made Minnesota the first state to implement fully its pay equity policy. The passage of the Local Government Pay Equity Act in 1984 extended Minnesota's policy leadership.

Minnesota is the only state in the union to require that all local jurisdictions use a comparable worth standard in assessing their wage policies and that they develop plans to remedy any inequities they may find. While numerous localities throughout the country have established comparable worth policies, either through local legislation or through collective bargaining, the scale of the effort in Minnesota is altogether different. Here 1,597 cities, counties, school boards, and special purpose jurisdictions are working to comply with a state mandate.

The University of Minnesota Comparable Worth Research Project collected data on the state of Minnesota, twenty-two Minnesota localities, and other comparable states and localities between 1984 and 1987. Most of the current research on comparable worth emphasizes the economic debate about how wage rates are set and what they reflect. Very little attention has been paid to the political and organizational results of adopting the policy. Our interest lies in exploring the concrete consequences, at both state and local levels, of implementing a

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comparable worth policy for public employees. In order to discuss our key findings, however, it is important to define comparable worth clearly and place the issue in its broadest historical and legal contexts.

How It Works

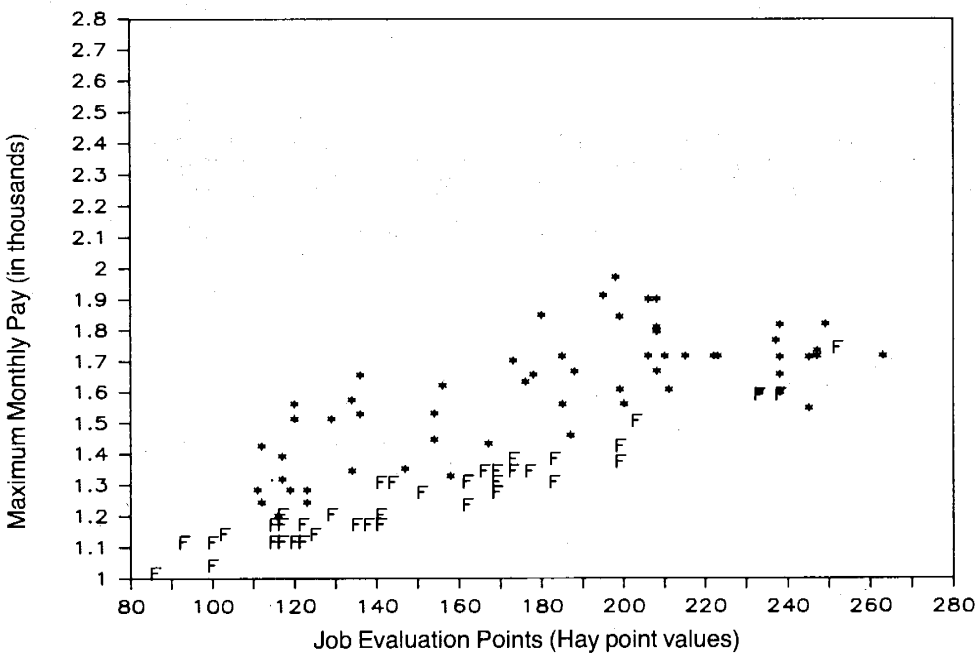
Comparable worth is a wage policy that requires equal pay for job classifications valued equally in terms of skill, effort, responsibility, and working conditions. In practice, implementing this policy requires applying a *single* job evaluation system to all job classifications within the same jurisdiction or firm. Jobs are most often evaluated and graded by a point system. Job classifications that are graded as being of equal value are paid equivalently. All individuals holding the same jobs within equal classifications are not paid the same wages, however, because seniority, merit, or quantity or quality of work done continue to differentiate individual wages within such classifications.

In theory, pay equity is more than pay for points, however. As the National Academy of Science has reported, pay equity is a remedy for the problem that "in many instances...jobs held mainly by women and minorities pay less at least in part *because* they are held mainly by women and minorities." Pay for points denies the historic undervaluation of female and minority labor.

A large number of studies have shown that if two job classifications have the same value according to the job evaluation system, but one is held primarily by men and the other held primarily by women, or one is held primarily by whites and the other by people of color, the job held by men or whites usually pays more. For example, the state of Minnesota used the results of a job evaluation system developed by Hay Associates to determine whether, at equivalent point levels, female-dominated and male-dominated jobs were paid equivalently. Hay Associates, a commercial job evaluation company, rated state jobs on detailed scales measuring skill, effort, responsibility, and working conditions. The sum of all the scales' scores equalled an overall score for each job. They documented that across the board jobs categorized at equal Hay point values that were dominated by women paid less than those dominated by men (Figure 1). Minnesota's analysis did not extend to comparisons of race and ethnicity because the state of Minnesota's workforce had only 3.8 percent people of color, a percentage higher than the total minority population in the state's population. Using a somewhat different methodology, the comparable worth analysis undertaken for the state of New York's employees included race, ethnicity, and gender comparisons and showed parallel findings.

Opponents of comparable worth, relying on a neoclassical view of economics, believe that wages should be established not by the value of a job to the firm or jurisdiction, but rather by what the market pays for each type of job. Comparable worth supporters respond, in the tradition of institutional economics, that the market embodies the customs and practices that encourage low wages for jobs filled by women and minorities. To supporters, the gender-, race-, and ethnicity-based wage differences that have been found for equally valued jobs are evidence that the market does not properly value the work traditionally done by women and minorities.

Figure 1. SALARIES FOR JOB CLASSES IN MINNESOTA STATE GOVERNMENT BEFORE PAY EQUITY



* = Male-dominated job classes (over 80 percent male)
F = Female-dominated job classes (over 70 percent female)
Balanced classes not shown

Source: Commission on the Economic Status of Women, *Pay Equity: The Minnesota Experience*. 1985, p. 12.

Origins

The movement for comparable worth arose in response to the persistence of wage differentials between women and men. It later addressed pay differentials between minorities and whites as well. In 1984, figures for full-time workers showed that white women earned 64 cents, black women earned 58 cents, and Hispanic women earned 54 cents for every dollar earned by white men. In the same year, black men earned 74 cents and Hispanic men 71 cents for every dollar earned by white men. While earnings differentials between minority and white workers have become narrower since World War II, earnings differentials between women and men have remained fairly stable until very recently.

The Equal Pay Act of 1963 and Title VII of the Civil Rights Act of 1964 did little to reduce the overall earnings differentials between women and men. To a large extent, this was because women and men do not for the most part have the same kinds of jobs. Occupational segregation is the watchword of most workers' job experience. According to 1980 census data, women workers, regardless of race or ethnicity, were likely to work in occupations that were two-thirds filled by women, and men were likely to work in jobs where 69 to 79 percent were also male, the variation depending on color. The more an occupation is filled by women or people of color, the lower its wage rate.

How did occupational segregation arise? Historically, women and people of color were only offered certain kinds of jobs. Laws and customs limited the jobs available to people of color. Women faced legal barriers to certain kinds of employment, were expected to assume the burdens of domestic work and child care, and operated, as did men, in a culture supporting separate spheres of action for women and men. Within this framework, employers routinely hired women and people of color at lower wages than white men or channeled women and minorities into occupations that paid less than those jobs held by white men though the level of skill required might be the same. Approximately half of the earning differential between women and men may be attributed to the residue of these social and economic arrangements. The other half stems from gender differences in education, numbers of years worked, interruptions in work life, and extra hours worked per week.

The history of comparable worth began

soon after World War I when the newly created International Labour Organization called for "equal pay for work of equal value." In the United States during World War II the War Labor Board created a policy of equal pay for equal work and very briefly supported a policy of equal pay for jobs of equal content, regardless of the sex of the worker. But sustained interest in equal pay and comparable pay did not survive the war years.

Not until 1963, when Congress passed the Equal Pay Act, did the "equal pay for equal work" standard become law, avoiding the comparable worth standard proposed in earlier versions of the bill. In 1964, Title VII of the Civil Rights Act created a general national prohibition against employment discrimination. Section (h) of Title VII, referred to as the Bennett Amendment, reconciled the provisions of the Equal Pay Act and Title VII with regard to women's wage discrimination claims. Title VII has become particularly important in implementing comparable worth because it has been interpreted as prohibiting not only intentional discrimination but also neutral policies that have an adverse impact on protected groups.

Legal and Political Context

One of the legal questions yet to be decided about the incorporation of the Equal Pay Act into Title VII is whether Title VII accepts a comparable worth wage standard. In 1981, in *County of Washington v. Gunther*, the Supreme Court ruled, albeit narrowly, on the relationship of the two acts, holding that Title VII was not restricted to the equal pay for equal work standard of the Equal Pay Act. Although the Court explicitly chose not to rule on the "controversial concept of 'comparable worth,'" advocates agreed that the Court had not precluded further consideration of comparable worth cases.

More recent federal opinions, especially the Appeals Court decision against a comparable worth claim made by state of Washington employees *American Federation of State, County, and Municipal Employees [AFSCME] v. State of Washington*, demonstrated that the weight of judicial opinion does not currently support a comparable worth interpretation of Title VII.

Harvard legal scholar Paul Weiler suggests that the future of comparable worth lies in the political process through legislation at the state and federal levels. In that regard, both the *Gunther* and *AFSCME* opinions indicate the importance of local, state, and national activism. Organized efforts for comparable worth are almost a decade old. Working from a base of several years of grass roots efforts, public employee unions, particularly AFSCME, joined women's organizations, minority groups and others to form the National Committee on Pay Equity in 1979. Opponents organized somewhat later, primarily through business associations like the United States Chamber of Commerce and the National Association of Manufacturers.

Litigation, legislation, and collective bargaining have been used to achieve comparable worth. Like many equity reforms, the early efforts have focused on the public sector. A growing number of state and local governments use or plan to use pay equity as the basis for compensation of public employees. As of April 1987, twenty-eight states had conducted job evaluation studies for state workers, and seventeen states had begun to make some kind of comparable worth wage adjustments, using legislative appropriations. The cost has generally been in the range of 2-5 percent of total payroll.

"And guess which one's salary we're getting 60 percent of?"

Comparable Worth in Minnesota

Numerous scholars have studied the economic and technical aspects of comparable worth, offering predictions about its feasibility and long-run impact. Very few, however, have followed the implementation process itself to discover the practical consequences of a comparable worth policy. On the basis of our research in Minnesota, we find that implementation raises new questions and highlights the complexity of technocratic reforms.

- **State Versus Local Implementation**

Differences between state and local implementation in Minnesota are dramatic. The state, which had a job evaluation system in place in 1979, conducted a comparable worth analysis of its wage policy in 1981 to identify female-dominated job classes that were below average male wages. Between 1983 and 1987, they negotiated the distribution of a special "pay equity" appropriation to these classes through the collective bargaining process. Key leaders both in the state Department of Employee Relations and in the dominant union of state employees, AFSCME, were also firm supporters of comparable worth, subscribing to the belief that women's market wages reflect historic discrimination. Together they constructed a "win-win" situation in which comparable worth raises were understood to be *an addition* to ordinarily bargained increases. AFSCME undertook considerable employee education among female-dominated employee groups and played the issue down among male employees.

A survey of 493 state of Minnesota employees, designed by the University of Minnesota Comparable Worth Project and fielded by the Minnesota Center for Survey Research in June 1985 showed that state workers supported the concept of pay equity and knew about the policy. In response to the question "If studies showed the work of delivery van drivers and clerk typists required the same level of skill, training, responsibility, and so forth, should an employer pay these types of positions the same?" 81.2 percent answered yes. There were some differences in level of support for the concept: 75.8 percent of men compared to 86.9 percent of women supported the policy. But even groups presumed to oppose pay equity largely gave it support: 79.9 percent of managers and 78.1 percent of self-defined conservatives believed that drivers and clerk typists should be paid equally.

State employees were knowledgeable about pay equity; 81.5 percent of the sample had heard of the policy and most understood its content. Of those knowing about pay equity, 94.4 percent correctly reported that men could get pay equity raises as well as women and 82.7 percent correctly responded that pay equity meant better pension benefits.

State employees had varying views of the consequences of adopting pay equity. Two-

thirds did *not* believe that pay equity caused many problems in the workplace. Both the unions and the Department of Employee Relations reported very few complaints about the policy or its implementation. Feelings that pay equity did cause problems in the workplace were most prevalent among those who thought that the women's movement had gone too far. This suggests that individuals fitted their evaluations of the policy into their existing belief patterns.

About 60 percent of the sample feared that salaries would be frozen as a result of pay equity, an action that did not occur and was never contemplated. This finding, which was evident regardless of the social groups or institutional groups to which employees belonged, indicated the unusualness of a "win-win" salary situation as well as employees' observations of local implementation, which was far more complicated.

Local implementation reveals a far more complex story due to a number of key differences. In the first place, whereas a relatively small number of leaders at the state level initiated and lobbied for the original legislation and then oversaw its implementation, local governments faced a state mandate to implement a policy that few managers or employee representatives understood. Most local jurisdictions had no job evaluation system either. As a result, comparable worth became inextricably bound up with the technical processes of job evaluation and, in some cases, reclassification.

Furthermore, the more fragmented and diverse labor forces of local jurisdictions had no clear voice, such as AFSCME provided at the state level. Male- and female-dominated employee groups were easily pitted against one another over what appeared to be a redistribution of scarce resources. As a consequence of these differences, comparable worth has generated far more conflict within local governments than it did with state government. It has easily become embroiled in other bureaucratic agendas (such as rationalizations for antiquated classification and wage systems).

• Leadership and Local Compliance

Given this high level of conflict, and the lack of sanctions against non-compliance, the notable thing about the Minnesota experience has been the high level of compliance. By August 1987, 80.5 percent of the counties, 76.3 percent of cities and towns, 93.1 percent of school districts, and 93.7 percent of special purpose districts had submitted reports to the Department of Employee Relations (DOER), and most of those still outstanding had comparable worth studies in progress.

Several factors contributed to this success. In the first place the state, through the DOER, remained extremely accessible and willing to provide technical assistance using its own experience as a model.

In addition, the leadership of professional associations (the Minnesota School Boards Association, the League of Minnesota Cities, and the Association of Minnesota Counties) encouraged compliance and offered strong direction throughout the process. The Minnesota School Boards Association in particular hired a consultant, Arthur Young Associates, to develop its own model system and then provided training for local school districts. At every stage, school districts complied in higher proportions than any other jurisdictional type.

In a different way, the League of Minnesota Cities made the technical assistance of the DOER available by inviting DOER personnel to present workshops at their regional meetings in the summer of 1984. These workshops constituted a first, and very positive, introduction to comparable worth for many small cities. And they were coupled with assurances that the process of compliance would be relatively simple. These small cities were the most likely to use a process of job matching with the state's Hay Associates job evaluation system that was offered to them with the assistance of DOER.

By contrast, the Association of Minnesota Counties, which had lobbied against the original bill, clearly opposed the concept of comparable worth and anticipated that the law could be changed or repealed. Nevertheless, when such attempts failed, the AMC also encouraged compliance and recommended the use of specialized consultants. Finally, one association, the Metropolitan Area Management Association, composed of Twin Cities suburban municipalities, initiated a massive joint study and hired Control Data Corporation to conduct it.

• Managerial Revolution

The compliance rate, and the choice of most large jurisdictions to develop new job classification and job evaluation studies in the process, resulted in a major unintended consequence, a kind of managerial revolution at the local level. The introduction of new managerial technologies into local governments prompted a number of jurisdictions to hire personnel directors for the first time. Managers, in many cases, now have access to accurate job descriptions for the first time. They know what their employees actually do, so they have a new basis for establishing wage policy and for allocating work. Unions find this a mixed blessing. Some unions that had taken advantage of irrationalities in the old system can no longer do so. When long-standing traditions, such as parity between police and firefighters, were disrupted, the response was highly emotional. On the other hand, female-dominated unions now have access to the information necessary to make their own case for higher wages much stronger.

• Wage Justice

The purpose of pay equity was to rethink what constituted wage justice, as Minneapolis Councilmember Kathy O'Brien, a strong supporter of the policy, recently remarked. From that perspective, one of the ways of evaluating comparable worth is to examine how it has changed wages.

The results at the state level are easy to document and dramatic. Take the position of Clerk 1, for example. If comparable worth had not been implemented the base pay of an entry level Clerk 1 in contract year 1983-84 would have been $11,922. If, four years later, the position had received its general pay raises of $1,753 but had not received pay equity raises, the base pay of an entry level Clerk 1 would have increased to $13,675. With comparable worth, entry level base pay for Clerk 1 position actually rose to $15,931 in contract year 1986-87, the year that comparable worth was fully implemented. Of the $4,009 increase in base salary, $1,753 came from regularly negotiated raises and $2,256 came from comparable worth raises.

Another perspective on these raises can be seen by comparing the entry level salaries for the Clerk 1 position to the poverty line for a family of four. In 1983, the poverty line for a family of four was $10,178 and the base salary for an entry level Clerk 1 before comparable worth increments were added was $11,922, or 117 percent of the poverty line. If over the next four years this position had only received the pay raises negotiated between the union and the state, the base salary of $13,675 would have been 122 percent of the poverty line (which was $11,203 in 1987). The actual salary of $15,931—the salary which included the completed implementation of comparable worth raises as well as general salary raises—was 142 percent of the poverty line. Of course, not every Clerk 1 lives in a family of four, but the salary change indicates that change in the capacity of people working as Clerk 1s to support or help to support their families.

What Next?

At the local level it is really too early to tell what all the economic consequences will be. Local policies—like comparing equally valued jobs to the average salary for those jobs, or using wage corridors that establish percentage limitations on raising or lowering wages to limit the increase or decrease of wages—indicate that economic changes at the local level will not be as great as they have been in state jobs. Nonetheless, preliminary figures from a suburban school district illustrate the very real impact that comparable worth policies can have. In 1985-86, a Health Associate earned an entering salary of $6.21 per hour. If the employee worked full-time for the school district (40 hours per week for 39 weeks), which many did not, the salary would be $9,688 for the year or 86 percent of the poverty line. Following the guidelines of its evaluation and reclassification study, the district proposed that the minimum salary

for Health Associates in 1986-87 be $7.75 per hour. This would raise a full-time associate's yearly salary to $12,090 or 108 percent of the poverty line.

Local unions supporting pay equity see their task as improving the techniques and monetary outcomes of the initial implementation over time. Local unions opposing the policy are functioning in a new policy atmosphere. Management has more information than ever before for dealing with the question of the value and wages for their employees. It is certain that the contest between managerial priorities, conflicting union interests, and wage justice will continue.

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The work of professors Evans and Nelson on the Minnesota Comparable Worth Research Project has resulted in a number of publications: "Comparable Worth: A Brief Review of History, Theory, and Practice" in the *Minnesota Law Review* (May 1985); "Initiating a Comparable Worth Wage Policy in Minnesota: Notes from the Field" in *Policy Studies Review* (May 1986); "The Impact of Pay Equity on Public Employees" a report to the Panel on Pay Equity Research, National Research Council of the National Academy of Sciences in 1987; "Mandating Local Change in Minnesota" a chapter in *Comparable Worth: A View from the States* (Ronnie Steinberg, editor, Temple University Press, forthcoming 1988); "Comparable Worth for Public Employees" a chapter in *Comparable Worth, Pay Equity, and Public Policy* (Rita Mae Kelly and Jane Bayes, editors, Greenwood Press, forthcoming 1988); and "Comparable Worth" in *Women's Studies Encyclopedia* (Helen Tierney, editor, Greenwood Press, forthcoming 1988). In addition Evans and Nelson have recently completed a book based on the project: *Wage Justice: Comparable Worth and the Paradox of Technocratic Reform*.

The Minnesota Comparable Worth Research Project began in 1984 with an interactive research grant from CURA and the Office of the Vice President for Academic Affairs at the University of Minnesota. Interactive research grants have been created to encourage University faculty to carry out research projects that involve significant issues of public policy for the state and that include interaction with community groups, agencies, or organizations in Minnesota. These grants are available to regular faculty members at the University of Minnesota and are awarded annually on a competitive basis.

Subsequent to CURA's funding, the comparable worth project was extended for two additional years with funding from the Northwest Area Foundation, the Humphrey Institute, the University of Minnesota Graduate School, the National Academy of Sciences, and the Kellogg Foundation.

Citizen Opinion on the Environment

by Thomas L. Anding and Christopher Klyza

As part of CURA's ongoing interest in the environment Minnesotans were polled in the summer of 1987 about a number of environmental issues and about what environmental problems they consider most important in Minnesota.

Respondents were asked specifically about five different environmental issues: a mandatory beverage container deposit law, garbage burning plants, the use of agricultural chemicals, the quality of drinking water, and the health threats of radon.

- **Mandatory Can and Bottle Deposit**. A large majority of Minnesotans favor making all cans and bottles returnable for a deposit. The results showed 86 percent favoring such a law and 14 percent opposing it. Similar legislation has already been made law in Connecticut, Delaware, Iowa, Maine, Massachusetts, Michigan, New York, Oregon, and Vermont.
- **Garbage Plants**. The vast majority of those polled also believe landfills should be replaced with garbage burning plants. Eighty-two percent favor such a move while 18 percent oppose it. These responses reflect the growing public uncertainty over waste disposal in landfills. A number of garbage burning facilities are being developed in Minnesota.
- **Agricultural Chemicals**. The use of agricultural chemicals is thought to be a problem by most Minnesotans. Forty-five percent of those surveyed saw it as a major problem, and 46 percent as a minor problem. Their attitudes may be tied to a growing and strong public concern with water pollution.
- **Drinking Water**. The concern with water pollution is also reflected in the survey question on the quality of drinking water in Minnesota. Forty-nine percent feel that water quality is getting worse, 46 percent that the quality is about the same, and only 5 percent that drinking water is improving in the state.
- **Radon**. When questioned about radon in the environment, only 49 percent of the sample had heard about radon. Of this 49 percent, 48 percent (or 24 percent of those surveyed) believed that radon is a serious health threat in Minnesota.

Minnesotans' view acid rain and water pollution as the two most important environmental problems facing the state in the next five years.

The question about ranking environmental problems was an open-ended one in which people were encouraged to state what they considered to be the two most pressing environmental problems. The first five named issues in order of importance, were:

acid rain	23 percent
water pollution	19 percent
waste disposal	10 percent
groundwater	9 percent
air pollution	7 percent

It is clear that Minnesotans continue to be most worried about pollution in general, since four of the top five concerns (58 percent) deal directly with water or air pollution. The next five problems mentioned were: hazardous waste disposal, surface water, nuclear waste disposal, landfills, and resource depletion. Consolidating the responses shows Minnesotans' concern about water (water resources and water quality, including acid rain) is high (58 percent), followed by general waste disposal

(23 percent), and air pollution (7 percent).

The survey was conducted during May and June of 1987 by the Minnesota Center for Survey Research (MCSR) as part of its omnibus state survey, the Minnesota State Survey. The results of the survey are based on completed interviews with 1,215 individuals throughout Minnesota. The Minnesota State Survey is conducted yearly by MCSR as a way for planning and research organizations to survey public opinion in Minnesota.

Thomas Anding is associate director of CURA. Christoper Klyza is a graduate student in political science at the University of Minnesota who has worked with CURA on a number of recent projects.

The survey was conducted in the early summer of 1987, from May 27 to July 6, the overall response rate was 74 percent. Those questions were part of the annual Minnesota State Survey conducted by MCSR at the University of Minnesota. This is an omnibus survey where public agencies, academic units, and other groups each pay for a few questions they wish to poll Minnesotans about. These are combined with a set of standard demographic questions so that current opinion may be examined by groupings such as sex, age, and income, as well. A random digit dialing system is used to contact households across the state. Within households another technique is used to randomly select an adult to answer the survey. Results have been weighted by the number of adults in each household to reduce bias from oversampling households with only one adult. The sampling error on a survey of this size is less than three percentage points.

Government Support for Child Care

by William J. Craig

A recent survey by the Minnesota Center for Survey Research (MCSR) asked 1,215 Minnesotans two questions about government involvement in child care. Those questions and their responses are given in Tables 1 and 2.

The questions grew out of a policy proposed by Governor Perpich last year suggesting that schools provide all-day kindergarten and child care for three and four year olds. The survey reveals that Minnesotans are undecided on the issue. Support for government provision of child care is not substantial and respondents are evenly divided on who should provide care if government funding were available.

Background

Since 1976 Minnesota government has helped pay child care costs for some low income working families under its Child Care Sliding Fee Program. The purpose of the sliding fee program is to assist those parents whose low incomes might otherwise be consumed by child care costs. Such people have shown a willingness to work and the state wants to encourage self-sufficiency. As family incomes grow and as children grow-up, support becomes less essential and is eventually phased out.

The questions on this survey did not focus on child care as a way of supporting low income households. They addressed the issue of a more broadly based program with educational emphasis as presented in the report of *The Governor's Commission on the Economic Future of Minnesota, 1987* (page 56):

> Research into educational outcomes demonstrates that early childhood learning programs pay off in reduced dropout rates, generally better academic performance, a higher likelihood of employment upon graduation and less dependency on public income support....The state should be willing to pay its fair share for expanded use of pre-school and afternoon development activities, as well as programs that are part of school curriculums.

Differences in Responses

In general, as Table 1 indicates, a substantial majority of Minnesotans do not endorse government support for child care for preschoolers of working parents. On the other hand, those most directly involved in locating and paying for child care are most in favor of government support. As shown in Table 3, women, persons of an age most

Table 1. IN GENERAL, SHOULD THE GOVERNMENT PROVIDE DAY CARE FOR THE PRE-SCHOOL CHILDREN OF WORKING PARENTS, OR NOT?

	Number of Responses	Percent	Percent of those Answering
Yes	459	38	40
No	695	57	60
Dk/na*	61	5	—

* Don't know/no answer. A small number of people could not be persuaded to answer these questions.

Table 2. IF THE GOVERNMENT DID START TO PAY DAY CARE COSTS FOR WORKING PARENTS, SHOULD THESE DAY CARE SERVICES BE PROVIDED BY LOCAL SCHOOL DISTRICTS? LICENSED DAY CARE PROVIDERS? OR SHOULD THE MONEY GO TO PARENTS WHO WOULD THEN PURCHASE THE SERVICES WHERE THEY WANTED?

	Number of Responses	Percent	Percent of those Answering
School districts	341	28	32
Licensed providers	371	31	35
Parents	354	29	33
Dk/na*	149	12	—

* Don't know/no answer. A small number of people could not be persuaded to answer these questions.

Table 3. IN GENERAL, SHOULD THE GOVERNMENT PROVIDE DAY CARE FOR THE PRE-SCHOOL CHILDREN OF WORKING PARENTS, OR NOT? (in percents)

	TOTAL	SEX		AGE		INCOME		HOUSEHOLD COMPOSITION		
		Male	Female	18-34	35+	<$25K	>$25K	Single Parent	Married Parent	Other
Yes	40	33	45	47	34	49	31	61	33	41
No	60	67	55	53	66	51	69	39	67	59

Table 4. IF THE GOVERNMENT DID START TO PAY DAY CARE COSTS FOR WORKING PARENTS, SHOULD THESE DAY CARE SERVICES BE PROVIDED BY LOCAL SCHOOL DISTRICTS? LICENSED DAY CARE PROVIDERS? OR SHOULD THE MONEY GO TO PARENTS WHO WOULD THEN PURCHASE THE SERVICES WHERE THEY WANTED? (in percents)

	TOTAL	SEX		AGE		INCOME		HOUSEHOLD COMPOSITION		
		Male	Female	18-34	35+	<$25K	>$25K	Single Parent	Married Parent	Other
School districts	32	32	32	32	32	28	35	37	30	32
Licensed providers	35	34	36	33	37	38	32	32	31	38
Parents	33	34	33	35	31	33	33	31	39	30

likely to have pre-school children, households with lower income, and single parents are most in favor of government support. In addition to groups shown in this table, those who identify themselves as Democrats are half again as supportive of this proposal as Republicans (48 percent compared to 31 percent).

Variation in responses to the question of who should receive government funds to provide child care (Table 4) is more complex and is also affected by individual circumstances. Categories in Table 4 are presented so that they will correspond with those in Table 3.

Some of the more interesting variations came in different groupings and these are mentioned here though they are not shown in the table. Those most favoring school districts were over fifty-five years of age (37 percent of this group selected school districts), had incomes over $25,000 (35 percent), were single parents (37 percent), were Democrats (35 percent), or worked blue collar jobs (40 percent).

Those who are more in favor of licensed providers receiving government support are younger than twenty-five or are forty-five to fifty-four years old (41 percent for the combined groups), earn under $25,000 (38 percent), are not parents (38 percent), are Republicans (38 percent), and work in technology, sales, administrative support, farming, or forestry occupations (39 percent combined).

The groups most supportive of giving money to parents who would then make their own decisions about where to purchase child care services are aged twenty-five through forty-four (37 percent) and are married with children (39 percent).

Conclusions

Public opinions are not well formed on government support of child care and on who might most appropriately receive government funds if available. Most people are opposed to government providing child care. Opinions on whether child care funds should go directly to parents or to potential providers (either schools or licensed providers) are divided. Public debate about child care may help direct opinions as people become more aware of the pros and cons of the various options.

Will Craig is assistant director of CURA and director of the Minnesota Center for Survey Research.

Open Enrollment in Public Schools

The Minnesota State Survey asked an additional question relating to children—a question designed to measure changes in attitudes about open enrollment.

> "Do you favor or oppose allowing parents of high school students to send their children to the public school of their choice regardless of location?"

Almost six out of ten people polled (56 percent) were in favor; 39 percent were opposed.* This shows a shift in favor of open enrollment over the past few years. A Northstar Poll taken in early February 1987 showed 47 percent in favor and 49 percent opposed on an identical question (St. Paul Pioneer Press Dispatch, March 1, 1987).

A 1985 survey by MCSR asked a similar question that can be used to show the longer term shifts in opinion on this issue:

> "Governor Perpich has suggested allowing parents to send 11th and 12th graders to any public school regardless of location, and having state aids transfer to that school along with the student...do you favor or oppose this?"

On this question in 1985, 30 percent were in favor and 66 percent opposed.

The shift in those favoring open enrollment has been substantial.

Survey Date	Favor	Oppose
Spring 1985	30%	66%
Winter 1987	47	49
Spring 1987	56	39

The 1987 legislature passed an open enrollment bill allowing school districts to participate in open enrollment at the discretion of their local school boards. To date 95 of the state's 435 districts have taken this option (22 percent). Only nine of the forty-six districts in the metropolitan area are participating.

*Numbers do not add to 100 percent because some people did not answer the question.

DRGs, Elderly Patients, and the Managerial Family

by Lucy Rose Fischer and Nancy N. Eustis

Hospital care of the elderly has been changing radically during the 1980s. One of the most pronounced factors creating this change has been the implementation, starting in 1983, of a prospective payment system under Medicare. Hospitals are reimbursed by a preset amount for each patient's care. Payments are determined according to Diagnostic Related Groupings (DRGs) based on the illness for which the patient is being treated. Prospective payment works to encourage efficiency by providing incentives to hospitals and physicians to limit the use of expensive procedures and to reduce length of stay in hospitals. The result is that patients now leave hospitals "quicker and sicker." Efforts to control inflation in health costs disproportionately affect the elderly since they are the largest users of Medicare and Medicaid. To date, however, few data have been published that assess the impact of DRGs on patient care.

This research began in 1982 as a study of interactions among family caregivers, elderly patients, and hospital staff; it was not originally conceived as a "before/after" study. Given our data set, however, it was possible to replicate and expand the investigation in 1986 to examine the impact of DRGs.

In both 1982 and 1986, in-depth interviews were conducted with hospital staff and with a small sample of elderly patients and family caregivers. Fifteen family caregivers were interviewed in 1982 and sixteen in 1986; eleven patients were interviewed in 1982 and nine in 1986. In both years some were too sick to be interviewed. In both years the patients selected were all sixty-five or older, were widowed (or at least lacked a functional spouse), were in need of post-hospital care, and had an adult child in the area. Sixteen hospital staff were interviewed in 1982 and thirty-six in 1986; interviews included administrators, nurses, doctors, social workers, and others. In 1982 the nurses interviewed were all from one ward; in 1986 more nurses and administrators were interviewed so that the implications of DRGs could be examined throughout the hospital. The staff interviews in 1986 contained many questions about DRGs. The family and patient interviews, however, were conducted with the same questions used in 1982, with only two questions about DRGs added at the very end of the interview.

"Good Care Hospital," (not the real name) where this study took place, is a high quality, non-profit hospital located in a well-to-do Twin Cities suburb. Since DRGs, there has been about a 5 percent decline in patients at Good Care—amounting to twenty beds empty each day, on average. Between 1983 and 1985 the average length of a hospital stay for Medicare patients in Minnesota declined from 8.9 to 7.3 days.

It should be pointed out that the effects of DRGs cannot be isolated from possible consequences of other trends in health care and other cost containment measures. In the Twin Cities metropolitan area, where Good Care Hospital is located, 36 percent of the population were enrolled in HMOs in 1984 and the health care marketplace is highly competitive. In addition, a widespread nurses' strike in 1984 resulted in hospitals reducing their nursing staffs.

The Transformation of Health Care

Recent changes at Good Care Hospital, which are associated with DRGs and other trends in health care, include an increased emphasis on cost, the intensification of hospital care, an increasing bureaucratization of the hospital structure, and increased emphasis on linkages between hospital and post-hospital care.

- **Cost Containment**. A crucial way that DRGs and other trends have affected health care is through an increasing emphasis on cost-accountability. A hospital social worker commented:

  > "Starting way back, we all went into this profession to be advocates for patients and a link for the community resources out there. That's still true, but we now also are advocates for the system. Health care has become much more business-like. We use marketing and business words now."

One evidence of the increased focus on cost-accountability is the fact that utilization review staff are to be present at all discharge planning rounds.

- **Intensification of Hospital Care**. Medicare patients are admitted and remain in the hospital only as long as they meet the criteria for acute care. Virtually all nursing staff interviewed in 1986 noted that their patients were sicker than in earlier years and many talked about their own problems with burnout. In the 1982 staff interviews, nurses often said that they did not have enough time to care for the social needs of patients. But, a number of the nurses in the earlier interviews talked about trying to do extras—like washing a patient's hair. In 1986, the nurses were much more likely to complain that they did not have time to "wait on" patients. For example, one nurse commented: "To me a hard patient is one who... demands your time to do little things like turning heat up or down..."

- **Bureaucratization**. DRGs appear to be challenging the authority of doctors by requiring them to accommodate their medical judgements to the requirements of a health care bureaucracy. As one doctor at Good Care put it: "The trouble with DRGs is they are rules. I don't object to rules, but there's so much biological variability out there that there's little left to the judgement of the doctor any more." It is also striking that doctors' admissions and discharges are now monitored by nurses who are assigned to do utilization review.

- **Linkages with Extended Care**. Because a larger portion of recuperation now occurs after the patient leaves the hospital, there is an increased need for coordination between in-hospital and post-hospital care. Between 1982 and 1986 home care providers proliferated in the Twin Cities as well as elsewhere. The 1986 staff interviews provide many references to linkages between hospital staff and extended care providers. Physicians, nurses, physical and occupational therapists, and social workers all described consultations with visiting nurses and with nurses and therapists at rehabilitation units or nursing homes. They also implied that such consultations were much more frequent and extensive than in the past.

Family Caregivers: 1982 versus 1986

Two major differences emerged in comparing family and patient interviews from the pre- and post-DRG years. First, the families and patients in 1986 were considerably more likely than those in 1982 to express concern about difficulties in hospital admissions, discharges, and quality of care. Second, the elderly patients in 1986 were more likely than in 1982 to return to their homes and receive home care services.

In 1986, all but one of the sixteen family caregivers in the sample expressed some concern about problems in admission or discharge.

> [A daughter about her mother:]
> "They only had her up one day before they sent her home. That day they gave her light broth and soft jello and she was not ready to go home. She was so weak. They hadn't walked her for a week. She barely sat up and it was very hard. (Did they tell you why she

Cost containment measures in hospitals are restricting the amount of care given there. Sons and daughters of elderly patients are alarmed by problems with gaining admission and preventing too early discharge for their parent.

was going home?) Well, because Medicare doesn't want to pay. They'd just like to shove them out."

[Another daughter about her mother:] "Then, you see, she was no longer on the Medicare after nine days in the hospital because she was eating and eliminating on her own. No matter that she was in terrible pain and under heavy Demerol and couldn't get out of bed—out you go."

[A son about his mother:] "They almost sent her home half dead because she didn't qualify for Medicare....They scared the living daylights out of me when they were going to kick her out on a Thursday and they told me they would discharge her at 8 p.m. and I said there was no way we could handle it. She's sick...."

The family caregivers, in talking about their problems with admissions and discharge, indicated a sense of incredulity, as if, despite what they may have read in the newspapers, they had not really anticipated that they and their families would be affected. Many of their comments reflected near misses. The parent was almost not admitted, or was nearly discharged too soon, but in the end some way was found for defending the admission or for postponing discharge in conformance with DRG guidelines.

Almost all the family caregivers and some of the patients in 1986 alluded to Medicare policies, and they did so before they were specifically asked about DRGs at the end of the interview. Their level of awareness, however, was quite limited. Only two of those in the 1986 interviews had ever heard of the term DRGs, and these were individuals who had professional ties with hospitals. One daughter was a nurse; another had worked as a patient representative. Moreover, in the 1986 interviews Medicare policies were almost always misconstrued. The most common mistake was that Medicare pays for only a fixed number of days. In fact, hospitals are reimbursed according to a fixed formula, based on estimates of average length of stay. Health care providers are specifically not to tell patients that they are allotted a set number of days.

In addition to problems in admission and discharge, almost half of the family caregivers (seven of sixteen) in the 1986 sample indicated problems with quality of care in the hospital. For the most part complaints concerned lack of attention to patients' social needs: not answering call lights, not helping a patient get to the toilet quickly enough, leaving a patient sitting on bedpan or chair for a long time even though the patient was in pain, or not helping a patient to eat. As noted earlier, the work load for nurses has intensified. Patients, generally, have greater need for medical care. There is therefore less time available for nurses to attend to social and routine care of their patients.

The contrast between 1982 and 1986 interviews with family caregivers is striking. In 1982 only one family caregiver spoke angrily about inadequacies in hospital care and discharge planning. The prevalence of problems mentioned in the 1986 interviews suggests that DRGs, along with other cost containment measures, have changed conditions and attitudes of both patients and family caregivers. The hospital is much more likely, now, to be viewed as a place where care is restricted or rationed. Family caregivers expressed concern that proper care would not be given to their parent.

The second difference between the two samples is that in 1986 patients were much more likely to return to their own homes

upon discharge, with the aid of some home care services. Virtually all of the patients returning home in 1986 used some form of home care services, such as Meals-on-Wheels or a visiting nurse. This is consistent with the large increase in home care options since DRGs began and also suggests that the DRGs environment increasingly places family caregivers in a managerial role, particularly in terms of interweaving formal and informal care.

The Managerial Family

Health care under DRGs entails two simultaneous trends: a greater need for a reliance on families and a proliferation of formal extended care alternatives. This juxtaposition suggests that a particular form of family caregiving for the elderly is emerging: the managerial family. Under the new DRG system, families do not necessarily provide increasing amounts of hands-on care to the elderly. Rather what has increased is the importance of families managing the health care of their Medicare parents. The managerial role for family caregivers means that they serve as mediators, supervisors, and planners.

- **Families as Mediators**. In 1982 at Good Care Hospital it was found that families mediated by making particular patients (their relatives) conspicuous and that this was especially important when patients were disoriented or too ill to speak for themselves. With the advent of DRGs this role has become even more important.

Current hospital structure requires doctors to translate diffuse medical judgements into specific codes and sometimes to balance opposing commitments to patient versus hospital. According to 1986 staff interviews, the DRG criteria make a distinction between "medical" procedures and all other care. Doctors and other staff soon learn that cost-accountability to the hospital means using this distinction. A nurse in the emergency room commented:

> "You have to play the role of patient advocate and call the doctor and explain the situation to see if some form of medical orders could be met to meet DRG requirements—for example, instead of ordering clear liquids, could the doctor order therapy for 24 hours? Instead of oral medication, could the doctor give medication through IVs to meet DRG requirements?"
>
> (Can that happen?)
>
> "Sure, it happens all the time. You can fudge it a little bit. It depends on what you're trying to get a patient admitted for; and certain DRG requirements we have down pat. If a doctor forgets to mention something in the orders, we'll say: 'You know we're not going to get your patient in unless you order this.'"

From the perspective of the health care professional, fudging is not really lying; rather, it emerges from the fuzziness of medical science. As one physician commented: "You fudge according to how you feel. I don't know if that's a real term, but it's putting down on paper why you're putting the patient there...With medicine there is no all-or-nothing...." Moreover, the doctor's professional commitment (as epitomized in the Hippocratic oath) requires that the physician place highest priority on medical quality.

Under these conditions, the very presence of family members is likely to exert some pull—so that families may help to influence physician's judgement. One daughter in the 1986 sample, for example, described what happened when her mother was in Alabama and the family was planning to airlift her from a hospital there to Minneapolis. They were told that the mother would be discharged from the Alabama hospital in twenty-four hours.

> "We were already arranging for the airlift, but with the commercial plan it took 72 hours, and the doctor refused to sign to let her stay two more days...we were not about to haul this poor lady with all her pain and Demerol and crazy in her head and everything to a nursing home for two days and then airlift her. So then my husband went to the doctor's office and he got pretty tough and the doctor wouldn't come out. He was barricaded behind four girls. Finally, they asked...where they could reach him and he said: 'Right here. I am staying here until I get a yes or no from this doctor.' Finally, the doctor sent out that no, he wouldn't. So, my husband went back to the hospital and was meeting with the administrator's assistant who said that the doctor had the final say and unless we would get the consent of the doctor [the mother would be discharged]. So my husband asked if he meant they would just put her on the curb and he said it might come to that. My husband said that he was going up to her room and, if necessary, he would put his body against the door and if they could get her over his body, they could take her out. Just then, up in her room, the doctor called...and he'd okayed the two days. Now, why didn't he say that right off? But I've heard since then that you have to squawk if you want to fight this Medicare thing..."

In this case, it was the intervention of a son-in-law that delayed discharge. The 1986 interviews with family caregivers provided many other examples of families influencing admissions and length of stay. In contrast, the interviews from 1982 showed that although families often represented patients in interactions with health care staff, the context was different because admissions and length of stay were not particular problems. In effect, under DRGs, the importance of family members as a lobbying force has been augmented.

- **Families as Supervisors**. The greater work load of hospital nurses under DRGs because their patients are sicker, suggests that family supervision of in-hospital care may also be more important. Evidence of this can be seen in the increased concern about quality of care expressed by families in 1986. The family members who complained, for example, that nurses did not respond to patient call-lights also attempted to rectify the situation. One daughter recalled:

> "...I looked at the board behind the nurses and my mom's light wasn't the only one on. So, I said to the head nurse when she finished [talking on the phone] and explained that my mom's light had been on for quite some time and I estimated it to be about 37 minutes and I noticed that there are three nurses down there who don't seem to be terribly busy. I wonder if we could get some help. She said, 'Well, is it an emergency?' I said, 'You don't know, do you. What if it were? 37 minutes worth of emergency! It isn't an emergency and it's fortunate for you that it isn't.'"

One of the economies instituted at Good Care Hospital was to transfer an increasing proportion of the nursing staff into a floating staff. Floating nurses are allocated as needed to cover variations in patient census on different floors. One nurse commented: "Something that's really out is continuity of care....There might be three nurses on our floor that are staff; another three are from the float pool." Floating nurses may be especially unable to assess changes in medical status, much less know about the patients' idiosyncratic feeding and toileting needs. In 1982 families also alerted nursing staff to the individual needs of patients. But there appeared to be a change in the degree of supervision required by 1986.

Supervision is even more important for post-hospital care—especially when care is given in the patient's own home. Home care entails a considerable amount of management. Visiting nurses or aides may or may not show up and they may or may not do their jobs competently. Families both watch over the reliability of paid helpers and provide back-up support. It is the family that provides continuity, among a potentially diverse set of formal care providers, and takes charge of the patient's overall recovery.

This supervisory role for adult children is difficult and likely to be stressful. One daughter in the 1986 sample quipped about the help she gives to her father: "I run two houses is what I do." The interview data suggest that since DRGs, as more post-hospital care is needed, families take on more responsibility for supervising a diverse array of home care options.

- **Families as Planners**. Discharge plans described by social workers, families, and patients in the 1986 study were strikingly varied. Two features of the family's planning role stood out. First, the hallmark of family caregiving is patchwork planning. Family caregivers are required to put together complex, idiosyncratic, and ever-changing arrangements for extended care. There appear to be few rules or guidelines. Arrangements reflect particular family relationships and family histories and the availability of services. Both formal service providers (such as home care nurses, rehabilitation units, and nursing homes) and in-

formal caregivers (most often close family members) are used. The complexity of this process is indicated in the following comments of one daughter-in-law:

> "...I spent hours on the telephone...first of all getting a nursing home. Then when she decided she was going to go home, getting a wheelchair, getting the nurses to come in, getting all the other things that she was going to have to have...I have Yellow Pages full of notes from calling. The first nursing organization that I called that had been recommended said yes, but they'd probably send somebody different each day, and I said that's much too difficult for an elderly person. So the one I called which I thought was going to be very good said...they would have one girl for four days and one girl for three days, which means she'd only have to get used to two people. And that sounded fine—and this is where we ran into this girl who bullied her and bought food for herself and none for her, and all that sort of thing...."

The need for home care has escalated and families are left to create a patchwork system of caregiving. The Goldblatt's (pictured here) finally arranged for a live-in helper, Wendy, to care for his mother Esther after she had a stroke. Bernie and Leslie Goldblatt (in background) both work full time.

Second, arrangements evolve over time and are subject to ongoing negotiation—both with the patient and with the network of other caregivers. As the conditions alter, new alternatives are put together. Family "planners" are continually making decisions about their own time and commitments and about enlisting others. This negotiation process is often difficult. In half of the families studied in 1986, patients resisted care—for example refusing to go to the hospital or canceling an order for Meals-on-Wheels. Such examples indicate an important distinction between responsibility and authority: adult children can be "in charge" of caregiving (responsibility) without being "in charge" of their parents (authority). Authority issues often stand out even more in relationships with other family members. A number of family caregivers described the difficulties of enlisting help from others—suggesting that they had no way to enforce compliance from relatives who, purportedly, were not doing their share.

To some extent, similar issues were found in 1982. Those interviews showed both that family caregivers often had heavy responsibilities for arranging care and that there were often authority problems (resistance from the parent or from other relatives). Since the implementation of DRGs, however, there is more reliance on post-hospital care. There also has been a dramatic increase in the number of home health agencies, particularly proprietary and hospital-based agencies. The data suggest that the planning role has become more conspicuous and more complicated.

In Conclusion

The health care environment has changed in several ways with DRGs—ways that accentuate managerial functions for families. First, rationing hospital care exacerbates the need for patient advocacy and protection. Second, Medicare patients, since they leave the hospital "quicker and sicker," are much more likely to need post-hospital care. Third, planning for post-hospital care has been speeded up so that more managerial responsibility is placed on family caregivers. Finally, options for home care services proliferate.

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Special thanks to Sister Kenny Institute for allowing us to photograph at their hospital. Sister Kenny was not the hospital surveyed in this research.

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