VIEWPOINT

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OF DIRTY SHEETS AND WORSE: ADMINISTRATION COSTS AND STAFFING MATTERS

I recently reread a distinctly memorable opinion piece for the July 1981 issue of *Social Work* titled "Dirty Sheets: A Multivariate Analysis." Written just as Reaganomics was launching into high gear and California's Proposition 13 had begun eroding public services, Henry Miller, a professor of social welfare at the University of California at Berkeley, commented on how "there's something real serious going on in social work today. It's no joy being a social worker in a deteriorating welfare state. . . . Everybody's worried about their jobs. Programs seem to be closing down all over the place, and those that are still running are hanging on for dear life" (p. 268).

This sounds familiar, I thought. Isn't everyone today worried about keeping their jobs? Miller went on:

> Take this big San Francisco hospital for instance. They don't even have enough money to clean the *sheets*. Can you believe it? Hospitals are supposed to be clean and sterile and all that—you know, no germs. They should smell and look clean. But here is a big public hospital in the Bay Area, and *the sheets are dirty*. The lab is spilling over with smeared test tubes and slides—nobody even scrapes off the blood. It's enough to make you cry—or laugh—or something. It's crazy! This isn't Calcutta. It's San Francisco and it's 1981. There's no money to mop up the puke in the hospital, and everybody's crabbing about how much taxes they have to pay. It doesn't make sense anymore. (p. 268)

Miller complained that the plethora of problems confronting urban society were escalating beyond control and, worse, that neither his social work students nor the profession seemed to care. He'd been told not to worry, that "social work always does well in bad times. The worse things get. . .the better off the profession is" (p. 269). Therefore, Miller reasoned, it was time for the social workers. However, according to Miller, "They've changed things around this time. We're not the cure anymore—we're the disease" (p. 269). He spelled out the new "cure": "They've called in the accountants and the scientists this time around. No more of that soft social work stuff" (p. 270). Accountants and scientists would ask the worthwhile questions, the hard questions, like "How much does it cost? Does it work? Can you measure it?" (p. 270).

Was Miller prescient? He was on to something, for in the 1980s the accountants and bean counters did take over health care. A recent study in the *New England Journal of Medicine* reported that in 1990 nearly one of every 10 health care dollars paid for hospital administration. Of the nation's $666.2 billion health care bill, $256 billion was spent on hospital

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care, and a whopping $63 billion of that—one-quarter—went for administration (Woolhandler, Himmelstein, & Lewontin, 1993). Administration means paper pushers, accountants, clerks, analysts, and executives, period. Not surgeons; not occupational therapists, physical therapists, radiology technicians, or nurses; not social workers; not even environmental technicians—nobody who treats patients. Administration means support costs, the clerks through the chief executive officers—people whose client is the hospital, not the patient.

In 1968, there were 435,100 managers and clerks for 1,378,000 patients, a ratio of about one to three. But 22 years later (after 18 years of Republican stewardship) hospitals were up to 1,221,600 administrators, while the average daily patient census had declined to 853,000. That's more than 1.4 administrators per patient, almost a tripling in the number of hospital administrators in a little more than two decades. One of every 10 health care dollars, and one of every four dollars of hospital revenue, is spent largely on the record keeping required to track billings required to do battle with competing hospitals over market share and with insurance companies over payments. Even states that have implemented hospital payment reforms that incorporate elements of managed competition show no lower levels of administrative costs (Woolhandler et al., 1993).

Isn't it interesting how casually administrative costs have been taken for granted by government, business, insurance companies, health maintenance organizations (HMOs), and—evidently—the general public? And despite a few pleas for more courageous and humane decision making (Ross, 1993), science regularly finds that social work in health care would be improved by even more actuarial analysis and automated decision making (Cuzzi, Holden, Grob, & Bazer, 1993; Dawes, Faust, & Meehl, 1989; Ginzberg, 1991; Levy, 1990; Mutschler, 1990; Siegler, 1987; Taylor, 1990).

In budgeting terms administration and information production are support costs required to tell us what we need to know to do the job. The test of whether administrative costs are necessary lies in how the information they produce is used. Managers have to remain cognizant of the purposes for which information is collected. What are decisions about? Who do administrators serve? Managers must think in terms of the effects of the system's operation and ask, Decision making for what? For containing costs? Or for improving patient care?

For what good end does administration operate? We know little of hospitals' outputs, their impacts on patients' health and the general health of their communities, and their effectiveness in meeting social needs. Possibly the volume of information being produced by hospital administrations has overtaken the institutions' ability to use it. The challenge to social workers in health care, especially in hospitals, is how to obtain and use the right information, that which clearly and validly identifies a normative standard for patient care and comfort and the activities necessary to achieve it and which targets patients at risk, both during and after hospitalization, who require extra attention. Social workers have to configure that information in meaningful ways and persuade their institutions to pay attention to it.

Things are changing quickly in hospitals, however, and believe it or not, the businesses, governments, and scientists who play information hardball are actually dreaming up ways to justify the collection of more, not less, data. Alternative performance measurement methods are constantly being proposed. One method is to track not only hospitals' spending and performance, but that of HMOs and large health care delivery organizations themselves, using ouputs rather than activities as the unit of performance measurement (Freudenheim, 1993). Purchasing alliances, for example, will compare such things as the percentage of baby enrollees with up-to-date immunizations, the percentage of women over age 50 who have had mammograms in the past two years, the rate of hospital admissions, and the number of days of hospitalization per 1,000 enrollees. Such alliances seem to want the information to make judgments about individual doctors' and hospitals' practices. Yet they are cautious about sharing such information with consumers, worried about whether patients can handle it and

unsure of what format and what kind of interpretative materials need to be provided with it. There are continuing worries about the completeness and reliability of the underlying data and that doctors and hospitals may concentrate more on getting good ratings than on improving care.

Such information is undoubtedly valuable, but it also has a cost, and the current system's problems require more than information alone. Setting care standards and performance targets is easy compared to the effort, cost, and commitment required to implement them honestly and humanely. Suppose we know that staffing is insufficient and that the hospital needs more money to increase staff and therefore improve performance. Then what is the use of the $60 billion administrative cost? Over and over in health care institutions serving poor people, administration sucks away available resources intended to implement improvements, while health care's most basic factors of production, hands-on and direct care workers, are sacrificed.

Have the accountants and the scientists improved health care in the past 12 years? Not according to a recent feature story headlined "Short Staffing Kills OB Patient." According to the story, on July 18, 1993, a healthy 22-year-old obstetrical patient, Lavonne White, collapsed in the delivery room at Chicago's Cook County Hospital during what should have been a normal delivery. Three days later she died, leaving behind a brain-damaged newborn with a tenuous future. White had received an overdose of magnesium sulfate while inexperienced residents and medical students disconnected her intravenous (IV) lines to take her to the delivery room. As a result she experienced cardiac arrest, and despite frantic attempts by the available nurses and staff to resuscitate her, she slipped into a coma. Three days later in the intensive care unit she died (Short Staffing, 1993).

Hospital line staff claimed that this "accident" was precipitated very directly by the shortage of nursing staff and the inadequacies of supplies and equipment that had become routine in the labor and delivery area at Cook County Hospital. Whereas one nurse for each patient in labor is the industry standard, according to the American College of Obstetrics and Gynecology, staff in labor and delivery at Cook County Hospital observed that maintaining this staffing ratio (a demand measure) would require 19 nurses per shift (a resource measure). Instead, there were routinely only seven to nine nurses during the day and five to seven at night.

There were six nurses on duty the night that White died. "Her" nurse was watching three other patients in labor in addition to White, yet she should have disconnected the IV lines herself and accompanied White to the delivery room. Not surprisingly in the busy, understaffed labor and delivery unit, residents and students often fill in for the overloaded nurses. Because English is not the primary language of many of these residents and students and social class differences are extreme, they communicate poorly with one another. Despite the circumstances, White's nurse was reprimanded and may well be fired.

The lack of equipment similarly violates the industry standard. Nurses at the hospital complained of not having enough IVACs (intravenous automatic control machines), and some in use lacked safety features that can prevent overdoses. The unit had nine IVACs, but it needed 25 to handle all medications correctly. Patients are frequently taken off intravenous medications inappropriately, rather than have them administered without an IVAC.

This hospital, like any hospital, relies on silence, complicity of staff, and guilt to be able to carry on such difficult business as usual. Shortly after White's death, however, 40 doctors from the obstetrics and pediatrics departments met to discuss and document the shortages in the labor and delivery unit. They sent a letter detailing the need for increases in nurses and equipment to the administration. That letter was signed by 220 doctors, nurses, midwives, and clerks. No other action is as effective as that kind of shared professional vigilance and righteous indignation.

The staffing cutbacks that are destroying Cook County Hospital and its patients are calculated and deliberate. A massive number of early retire-

ments took effect on July 1, after the hospital offered incentives to encourage them. The hospital eliminated agency nurses a year ago, and nurses no longer want to work overtime in the labor and delivery unit like they used to. Nurses complain that they have to spend more time on paperwork than on patient care and that the responsibility laid on them is too great. They do not feel in control and object to having to accept blame when things go wrong. As at many hospitals in Chicago, a large proportion of Cook County Hospital's 50 social workers have been laid off in the past year. Such short staffing has become commonplace throughout the country (Noble, 1993).

Nothing has changed since White died. The same shortage of nurses continues, students and residents are still running the IVACs, and no additional IVACs are available. Staff claim a tragedy could happen again. The social workers who were left had to place White's disabled baby with its grandparents, whose home had recently burned down. They are dancing across an ethical minefield: Should they give the family details about the death, help them get a lawyer, suggest that they sue, help them apply for public aid? Should they give consumers information they may use? Should they expose, further obscure, or simply ameliorate what is a reprehensible tragedy? It is all too late for the White family.

There is a serious lesson here about performance measurement. Practitioners must think in terms of measuring "inputs," the raw resources required to do the job. Experienced practitioners, including social workers in hospitals serving poor people, should know the human resources required to provide patient care adequately and responsibly. We need to know the resource and care standards for different health care settings and the regulatory bodies that oversee them, recognize the signs of staff burnout and dangerously low morale, help develop federal staffing standards such as those advocated by the Service Employees' International Union (Noble, 1993), and know where and to whom to report deficiencies. Unconscionable practices accompany violations of resource standards. And when that happens, and the social worker has exhausted every other venue, he or she should mobilize other patient care workers and use contacts in the local press.

Interestingly, a recent NASW survey about the changing role of hospital social workers asked about the ratio of social workers to patients before and after reorganization of hospital social work departments, but few respondents could answer that question (Landers, 1993). I wonder why not. If we do not know, we are a part of the problem.

Information systems are only as smart as the people who use them. Without strong, fearless direction in hospital social work, without leaders willing to expose information and put a more informed "spin" on it, the costs of administration are wasted. We need that leadership now. The health care reform struggle facing Congress will probably take at least a year, and full implementation is not expected until 1998. In the meantime we will continue to wait for new benefits to trickle down to inner-city obstetric departments. Vigilance is needed now more than ever, at every level of fiduciary responsibility, to keep hospital management honest. We must not let our public hospital infrastructures deteriorate further just when our nation is about to commit to serving poor people better and when the traditional expertise of public hospitals is needed most.

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