

**AGITATION AND CONTROL: A TACTICAL ANALYSIS OF THE CAMPAIGN
AGAINST NEW JERSEY'S QUALITY HOME CARE ACT**

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Abstract

A shortage of home health aides has forced the institutionalization of some consumers who could otherwise be cared for at home. Chief among the many factors that limit the supply of home health aides is the profession's low rate of pay and scant benefits. Unionization could be a positive force in alleviating the labor shortage. To date the Service Employees' International Union (SEIU) has achieved tremendous success organizing home care paraprofessionals. Unionization and the establishment of public authorities have produced a substantial improvement in pay and benefits throughout Washington and Oregon, as well as in California's larger cities and suburbs.

A distinguishing feature of the three Western states is that the non-governmental sector had been relatively uninvolved in the provision of home health care. Elsewhere, public authorities could have the effect of driving both private sector for-profit and non-profit competitors out of business. Therefore, the labor movement must anticipate a higher level of employer resistance as it seeks to replicate its West coast successes. This research analyzes the strategies and tactics used by employers opposed to homecare policy reform in New Jersey. The opposition was well organized and voiced a cohesive message, indicating a high degree of behind-the-scenes coordination. The analysis draws on the literature on business political activity and on the framework of agitation and control. This framework has been applied extensively to the study of communication patterns employed by supporters of social movements and their opponents who wish to maintain the status quo. Finally, lessons learned from this encounter with organized opposition are discussed.

Introduction

As Hubert Humphrey (1977) once noted "...the moral test of Government is how that Government treats those who are in the dawn of life, the children; those who are in the twilight of life, the elderly; and those who are in the shadows of life, the handicapped." A moral test is facing policy makers across the U.S. in the form of a direct-care crisis. The direct care segment of the health care industry is characterized by increasing demand for services coupled with a shrinking supply of paraprofessional care workers.

The urgency of this impending crisis and the need for public solutions are well documented (Benjamin and Matthias 2000; Dawson and Surpin 2000; Gerrick 2003, Hewitt and Lakin 2001; Munchus, Roberts, Rivers, and Gingerich 1999; Standing 2001; Stone, 2004; Health Resources and Services Administration 2004; U.S. Government Accounting Office 2001; Wilner 2000; Yamada 2002). The ever-widening gulf between the demand for and supply of home care services intersects health care, welfare, and labor policy environments. However, coordination between these policy environments is lacking (Paraprofessional Healthcare Institute 2001).

A recent study conducted by the Health Resources and Services Administration (2004) concluded that a variety of factors influence the supply and demand of direct-care paraprofessionals. These factors can be broken down into two categories: exogenous factors over which policy makers have little or no control, and policy levers over which policymakers have considerable influence and control. The factors identified as policy levers include: compensation of workers, treatment of workers, unionization,

reimbursement rates and criteria, worker education and training programs, government regulation, and new models of care and service.

This research presents a case study of a to-date unsuccessful attempt to replace publicly funded, private-sector homecare agencies with public authorities in New Jersey. First, the nature of the emerging crisis in home health care in New Jersey and the history of public authorities are reviewed. Next, the New Jersey Quality Home Care Act, legislation that was introduced in 2003 as a means to solve the state's home care crisis, is described. Then, the strategies and tactics used by employers opposed to homecare policy reform in New Jersey are analyzed. The analysis draws on the literature on business political activity and on the framework of agitation and control. This framework has been applied extensively to the study of communication patterns used by supporters of social movements and their opponents who wish to maintain the status quo (Bowers and Ochs 1971).

Market Failure in the Home Care Industry in New Jersey: A Mismatch of Supply and Demand

Growing Demand for Home and Community-Based Services

Home health care, a rapidly changing sector of the health care industry, has experienced remarkable growth over the past decade. As of 2001 there were more than 20,000 home care agencies nationwide providing services to over 7.6 million individuals who require care due to acute illness, long-term health conditions, permanent disability, or terminal illness (National Association of Home Care 2001). The following factors are driving the increase in demand for home- and community-based services: demographic

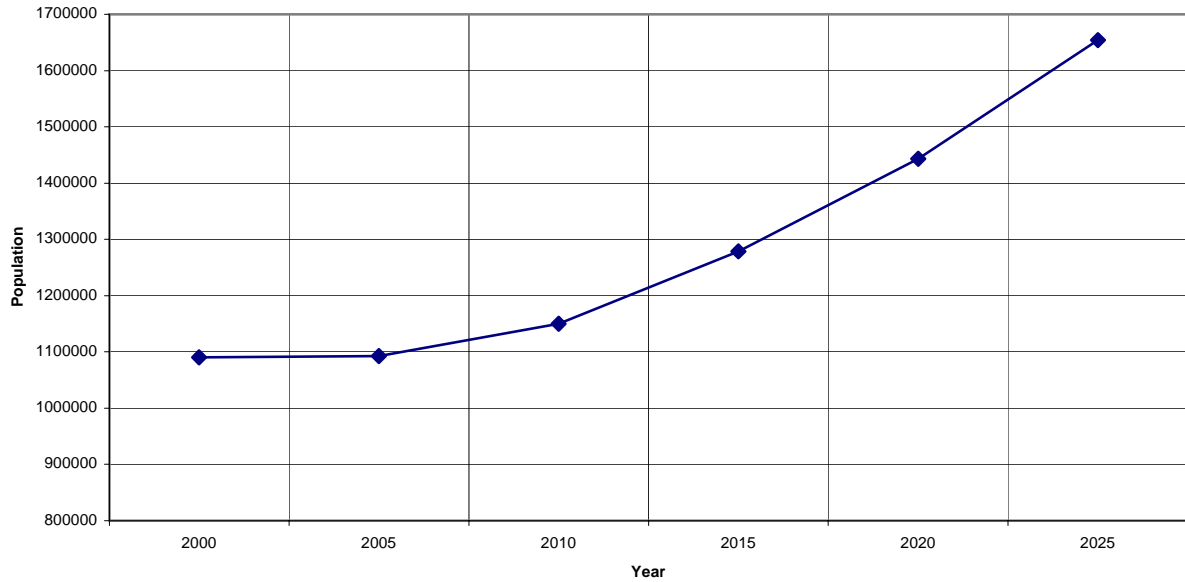
characteristics of the population, public advocacy, public policies, legal decisions, and technological advances (Health Resources and Services Administration 2004).

Among the most important driving forces is an increase in the population of elderly and disabled New Jersey residents. From 2000 to 2025, the population of elderly residents of New Jersey is expected to increase from 1.09 million to 1.65 million (see figure 1) (U.S. Census Bureau 1996). In 2000, almost one million non-elderly state residents were disabled (U.S. Census Bureau 2001). While it is difficult to project changes in disability rates, particularly for individual states, there are many reasons to anticipate an increase in the disabled population.

Despite remaining fairly constant during the 1980s, disability rates have risen rapidly from 13.7 percent in 1990 to 15 percent in 1994 (Kaye, Laplante, Carlson, and Wenger 1996). The relationship between an aging population and disability rates is readily apparent. To illustrate, in 1997 roughly three out of four Americans over the age of 80 were disabled. In addition, medical advances have improved survival rates for a wide variety of diseases and traumas. For instance, there have been significant improvements in survival rates for persons with spinal cord and severe brain injuries. Likewise, over the past 25 years the survival rates of low birth-weight infants has increased dramatically. The improved survival rate for these infants has had a direct impact on the occurrence of developmental conditions and learning impairments (Fujiara 2001).

Figure 1

Projected Growth in New Jersey's Elderly Population
(Source: U.S. Bureau of the Census 1996)



Another key factor in the increased demand for home health care is the independent living movement. The underlying theme of the independent living movement is that people who require care prefer to have services provided in their own homes or in home-like settings. As noted above, due to medical advances more young people survive diseases, injuries, and other disabling conditions. As a result there are more young adults with disabilities (Reinhard 2001). Receiving care at home allows these individuals to maintain their dignity and independence.

Moreover, home care affords individuals an opportunity to take an active role in their care (Munchus et al. 1999). Elderly adults are also beginning to seek home care as the preferred alternative to care in institutional settings such as nursing homes (Reinhard 2001). Over the past three decades, advocates for independent living have created

political pressure to expand public funding for home health care and to provide customers a greater voice in their own services and support (Benjamin 2001). New Jersey's senior citizens overwhelmingly approve of an increase in the level of funding for home care (AARP 2003).

Over roughly the same period, public policy has changed in a variety of ways. For example, the Omnibus Budget Reconciliation Act of 1980 modified coverage restrictions on home health benefits, reduced eligibility requirements, and expanded market participation by private, for-profit agencies. In 1983, the Prospective Payment System (PPS) for Medicare provided incentives for hospitals to discharge patients earlier. This allowed the focus of home healthcare services to change from long-term care for chronically disabled adults to short-term care for adults, especially post-hospitalization (Henton, Hays, Walker, and Atwood 2002). Similarly, the U.S. Congress has attempted to reduce Medicaid expenditures in institutional settings and to expand Medicaid coverage for home- and community-based services. In 1970 the U.S. Congress made Medicaid coverage of home health services mandatory. In addition, states may elect to provide community-based services under Medicaid (Wallack, Sciejag, and Long 2002).

In keeping with these trends, the state of New Jersey has developed its own programs. For example in 1988 New Jersey implemented the Community Choice Counseling program for Medicaid-eligible nursing home residents. The goal of this program is to move elderly persons from nursing homes back into the community (Howell-White, Palmer, and Bjerklie 2001). Also, in 1988 New Jersey implemented the Statewide Respite Care Program (SRCP). One of the primary goals of the SRCP is to delay institutionalization of frail elderly or disabled adults (Silberberg and Caruso 2001).

These programs and others like them that offer incentives to seek home and community-based care as an alternative to care in institutional settings have contributed to the growing demand for home health care in New Jersey. New Jersey still spends 80% of long-term care dollars on institutional care, but a recent report called for this percentage to be halved (Reinhard and Fahey 2003).

On the legal front, a landmark Supreme Court decision in the case of *L.C. & E.W. v. Olmstead* ruled that states violated the Americans with Disabilities Act by confining disabled individuals to institutions when they could be served more appropriately in community-based settings. Twenty states have responded to this decision by establishing *Olmstead* web sites, eighteen states have issued compliance plans, and three states have begun to implement these plans (Fox-Grange, Folkemer, Straw, and Hansen 2002).

Although New Jersey is not among any of these leading groups of states in addressing this issue, the *Olmstead* decision will eventually force states to provide more home- and community-based services in order to comply with the Act.

Technological advances have spurred demand for home health care in various ways. For example, advances in medical technology have enabled people to live longer, increasing the potential customer base. In addition, technological advances have made it easier for persons to be cared for in their own homes as opposed to institutional settings. Specifically, improvements in portability have made it cost-effective to provide medical services in the home (Munchus et al. 1999).

The Shortage Of Home Health Aides

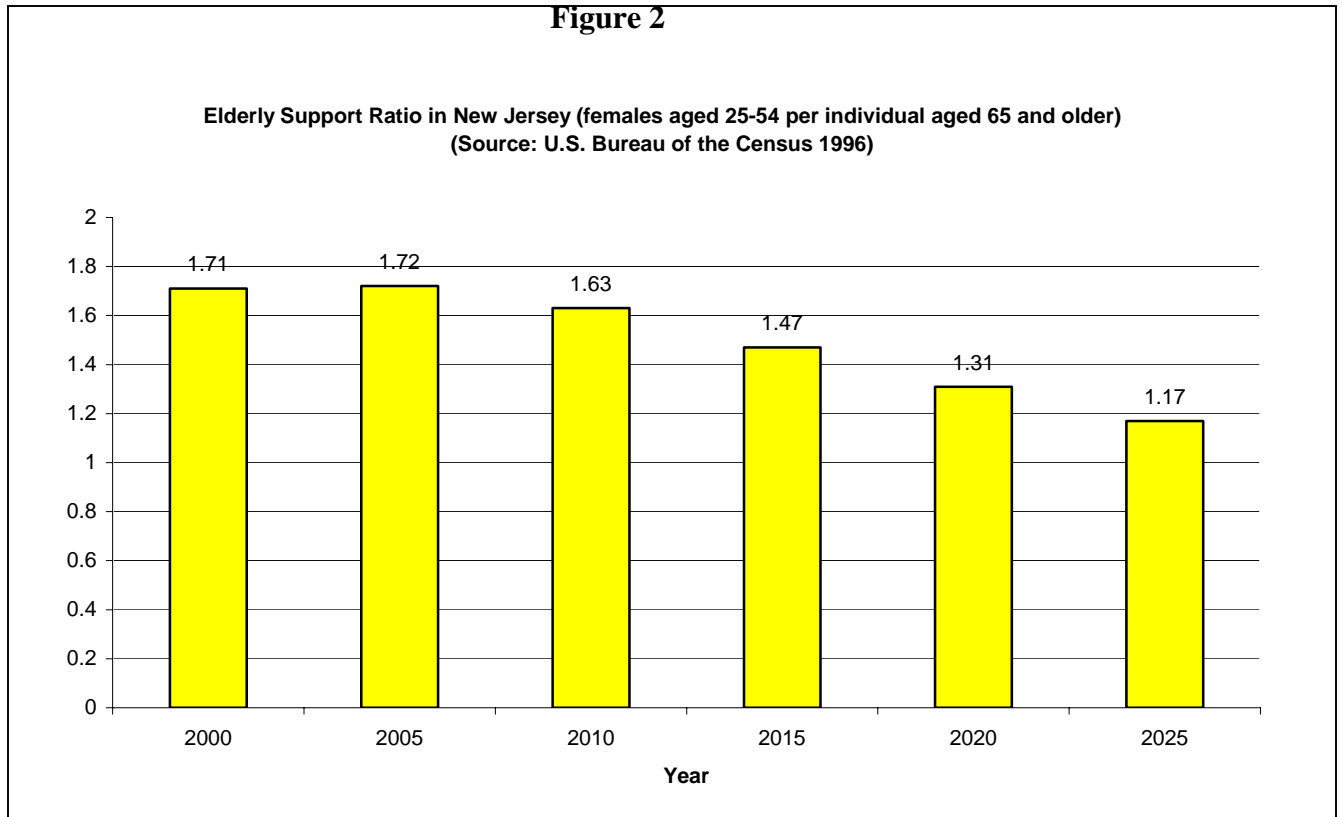
On a national basis, home health aide and home care aide are the fifth and eighteenth-fastest growing occupations, respectively. They are the only two in the top

twenty fastest-growing occupations that pay in the bottom quartile of median hourly earnings. Demand for these jobs is expected to increase by 44%, or 525000 workers, between 2002 and 2012 (Bureau of Labor Statistics 2004a). In New Jersey, the demand is rising even more quickly. Demand for these jobs in the state is projected to rise by 47%, or 36200 workers, over the period of 2002-2012 (New Jersey Department of Labor 2004).

At the same time that demand is rising, the home care segment of the health care industry faces a persistent and growing labor shortage. Traditionally, home health aides have been women aged 25-54. Compared to elderly Americans, this segment of the population is growing much less quickly, creating a worsening “care gap.” An elderly support ratio can be calculated, consisting of the number of women aged 25-54 divided by the number of men and women aged 65 or greater. At the national level, in the year 2000, when shortages of home health aides are already being felt, this ratio equaled 1.74. By the year 2030, it will decline by almost half, to a level of 0.92 (Paraprofessional Healthcare Institute 2001). As figure 2 demonstrates, New Jersey also faces a declining elderly support ratio. Although the care gap in New Jersey is slightly less severe than at the national level, it remains cause for concern.

Besides demographic trends, a variety of work-related factors have contributed to the chronic shortage of home health care aides. Low pay and lack of benefits are primary causes of the shortage. The effects of inadequate levels of compensation are compounded by a lack of respect on the job and the lack of opportunities for advancement (Case, Himmelstein, and Woolhandler 2002; Kendra 2002; Rossman 1997; Yamada 2002).

Figure 2



To illustrate, in 2002 the national median hourly earnings of home health aides and home care aides were \$8.07 and \$7.81, respectively (Bureau of Labor Statistics 2004b, c). Nearly 20% of direct care paraprofessionals live below the poverty level, making them much more likely than the average American to be poor (Health Resources and Services Administration 2004). As Guy and Newman (2004) note emotional labor, that is, relational tasks such as caring and nurturing are mainstays of health and human service jobs and paraprofessional work. Indeed as one home care attendant describes her work, “The reward of this job is that I can help people stay in their home. You can come into a client’s life and just be the tonic they need. I can’t help but think, ‘there but for the grace of God go I’” (Leigh 2000). Caring and nurturing tasks have been defined as

natural behaviors inherent to the individual. As a result, care work has been systematically devalued (Guy and Newman 2004).

In particular, the wage structure in home health care is influenced by social expectations that female family members will care for the elderly or disabled as a “gift,” without monetary compensation (England and Folbre 1999, Ness 1999, Walsh 2001). To illustrate one home care worker notes, “A lot of people don’t understand how important our work is...wiping noses, holding hands, often being the only ones our clients have to talk with. And the thing is, how will these people feel when *their* parents or *they themselves*, are so dependent on someone who’s earning barely \$8 an hour with no benefits to provide the most intimate of care” (Morgan 2000).

Since most data on benefits are proprietary information, researchers often rely on self-reports of home care aides collected through the Bureau of Labor Statistics’ Current Population Survey. Even when the same source is used, researchers disagree on the exact calculation of benefits provided. For example, in recent studies estimates of the proportion of home health care aides receiving health care benefits through their employment range from 26% to 47.3% (Yamada 2002, U.S. General Accounting Office 2001). When employers do provide health insurance plans, the high costs of participation frequently prohibit effective utilization by these low-wage workers (Seigle 2001, Health Resources and Services Administration 2004).

Similarly, estimates of the proportion of home health aides covered by employer-provided pensions ranges from 21% to 24% (U.S. General Accounting Office 2001, Yamada 2002). Nevertheless, researchers agree that home health care aides receive lower wages and benefits than workers generally and have much higher poverty rates than the

national average. In fact, home health care aides are more than twice as likely as other workers to be receiving food stamps and Medicaid (U.S. General Accounting Office 2001, Yamada 2002). Some home care workers also receive health care coverage through other government programs such as Medicare and CHAMPUS (Health Resources and Services Administration 2004).

Another fundamental problem underlying the shortage of home health aides is management practices. For example, the industry policy of scheduling home health visits in the morning makes it very difficult for home health aides to work a sufficient number of hours per week (Dawson and Surpin 2000). Furthermore, supervisors of home health aides use a very autocratic leadership style. The home health aide is to make no independent decisions relating to patient care without first consulting with the supervisor. This mimics the relationship in hospitals between nurses and nurses' aides. However, it is particularly frustrating to front-line workers in the home health care context because the supervisor sees the patients so much less frequently than does the home health aide (Rossman 1997).

In addition, there is little opportunity for advancement. The supervisor is usually a registered nurse, physical therapist, or social worker (Bureau of Labor Statistics 2004c). Since home health aides usually do not have college degrees, they rarely qualify for promotions (Yamada 2002). Taken together, these factors make home health care jobs unattractive compared to positions in retail sales or fast food service where the jobs are safer, less demanding, and better paid (Health Resources and Services Administration 2004).

Policy Options: Bringing the State Back In

The direct care worker has been described as the “third rail of home care policy” (Stone 2004) because the system of government-funded home-care cannot expand without an increase in the supply of these kinds of workers. Several states have attempted to alleviate the shortage of home health aides by enacting “wage pass through laws”, increasing their reimbursement rates to home health agencies in exchange for their promise to raise the pay of home health aides. The continued labor shortage attests to the limitations of these laws absent strict enforcement. There are three possible explanations. First, it is possible that the home health agencies pocketed the money and did not pass it through to the workers. States tended not to vigorously monitor the home health agencies to ensure that the increased reimbursement rates led to pay increases (North Carolina Division of Facility Services 1999).

Second, the amount of money passed through may have been too meager to have a meaningful effect on the labor shortage. For example, the amount passed through is typically lower than the average annual increase in wages (North Carolina Division of Facility Services 2000). Finally, wage pass through legislation does not directly address the other issues that make home health care unattractive, as discussed previously--limited promotional opportunities, risk, low benefits, and lack of respect.

Another policy option is known as the public authority model. The public authority model of home health care delivery has been adopted in three states: California, Oregon, and Washington. Certain elements of the model are the same in all three states. First, in all three cases the union had to establish a clear chain of employment responsibility between caregivers, recipients of care, various levels of government, and

existing public policies that influenced the provision of care. Second, while the client retains hiring and supervisory control over the home care worker, a public authority serves as the employer of record for all home care workers in a particular geographic area. Third, the workers are granted the right to bargain collectively. Finally, the workers forfeit their right to strike.

Although the agreements do not guarantee the security of particular home-care jobs, they do provide representation and work security for caregivers. While the union does not represent home-care workers in individual work places, it does make workplace issues public policy issues, by representing workers in the political arena. Given the nature of home care work, the arenas of politics and public policy are critical to securing improvements for these workers. In addition, the public authority interacts with consumers and workers to establish a registry of home care providers and improve training opportunities. The registry serves to keep workers in more continuous employment and to move workers out of situations in which conflict arises with the recipient of care (Walsh 2001).

The establishment of the public authorities, and the subsequent decision of tens of thousands of home care workers to unionize, has been hailed as labor's biggest victory in over sixty years (Smith 2000). However, the model has not been equally successful in all three states. California, the first state to adopt public authorities, has achieved the most mixed results. In California, each county has its own public authority which negotiates its own contract with the union. The SEIU's website boasts of improvements in San Francisco, Sacramento, and Los Angeles (Service Employees International Union 2004). However, the picture in the more rural counties is much bleaker. Although the state

reimburses each county for 65% of the compensation of their home care workers, the rural counties are concerned about delays in payments from the state and the possibility that Governor Schwarzenegger could reduce or eliminate the subsidies. Accordingly, some counties still pay the minimum wage with no benefits to home care workers (Boyles 2004).

These concerns are not unfounded. Recently, Governor Schwarzenegger proposed cutting \$495 million from the state's In-Home Supportive Services (IHSS) program (Meyers 2004). As part of the budget-cutting plan the governor would also reduce wages paid to home care workers, putting them back at a minimum wage of \$6.75 per hour. Only after consumers protested, did Governor Schwarzenegger's administration seek federal funds to shore up the IHSS program. Members of the Governor's administration even threatened to dismantle the IHSS program if the request for federal funds was unsuccessful (Gledhill 2004).

Eventually, Governor Schwarzenegger backed down from his plan to abolish IHSS on the understanding that the state would receive an increase in Medicaid funds from the federal government (Herdt 2004). The current year promises a new clash, as the Governor again plans to trim the IHSS budget by almost \$200 million while no new infusion of federal funds is anticipated (Sheehan 2005).

At this time, the public authority model seems to have exacerbated inter-county pay differences between home care workers. To the extent that home care workers can move from one county to another, California's public authority model may be improving the delivery of home health care in major cities while worsening the availability of home care workers in rural counties. Consumers in rural areas receive lower quality home care

than their urban counterparts (Schlenker, Powell, and Goodrich 2002). Any factors that reduce the availability of home care aides in rural areas will exacerbate this quality gap. The county-based nature of the IHSS system also poses a continuing challenge to the union because it increases the cost of representation compared to a statewide bargaining unit.

Is it better to have a public authority in each county than to leave the delivery of home health care to the private sector? A somewhat surprising conclusion can be made based on a comparison of California and New York. New York delivers its home health care through a network of subcontractors, many of whose employees are represented by the SEIU. The outcomes achieved by the union in these two states are very similar. For example, the median hourly wage for home care aides is \$8.41 in California and \$8.14 in New York (Paraprofessional Healthcare Institute 2004).

In both states, home health aides in large cities and their suburbs have earned handsome wage increases as well as health insurance for union members. Their rural counterparts have seen few improvements in their working conditions, often continuing to be paid the minimum wage with no health insurance. For example, California's highest paid workers are in Santa Clara County (\$12.03/hr), but about twenty counties still pay minimum wage (Osterman 2005). In New York the state budget allocates funds for home care workers' health insurance only in New York City and three suburban counties (Hammond 2003).

In Washington and Oregon the SEIU crafted statewide bargaining agreements that raise wages and offer health insurance to every home health aide who works a minimum number of hours per month. For example, in Oregon the 2003-2005 collective bargaining

agreement raised home care workers' wages across the state to \$8.96/hour as of July 1, 2003, with an additional increase to \$9.26/hour as of January 1, 2005 (SEIU 2003). Similarly, in Washington the 2005-2007 collective bargaining agreement raises home care workers' wages across the state to \$9.20/hour as of July 1, 2005. As of July 1, 2006 home care workers across the state will receive additional increases bringing their hourly wage rates to between \$9.43 and \$10.31 depending on their cumulative career hours (SEIU 2005). So, statewide public authorities appear to be the most promising alternative for addressing the home health care crisis. They lead to the most substantial statewide improvements in home health aide compensation and therefore are most likely to alleviate the labor shortage.

However, a distinguishing feature of all three Western states is that the non-governmental sector had been relatively uninvolved in the provision of home health care. Thus, the efforts to establish public authorities in these states met with minimal resistance from private-sector agencies. Statewide public authorities arguably offer the best hope for expanding the availability of home health care. In states such as New York and New Jersey, these institutions would have the effect of driving the existing network of subcontractors out of business.

Implementing public authorities nationwide would require a strategy for dealing with employer resistance, because they would tend to drive competitors out of business. The process that employers use to persuade governments and voters to adopt favorable public policies is known as business political strategy. The sections that follow summarize some of the relevant literature on business political strategy and discuss an attempt to replace private sector agencies with public authorities in New Jersey. New

Jersey's experience has important implications for the labor movement and other advocates of the expansion of home health care.

Business Political Strategy

The study of business political strategy is complicated by its lack of a unifying theory (Getz 2002). Nor is there a consensus among researchers with respect to a typology of business political strategies and activities (Hillman, Keim, & Schuler 2004). Nonetheless, business political strategy research yields a number of informed predictions about the efforts that private-sector agencies would take to protect their turfs from statewide public authorities.

First, constituency building is an effective technique that businesses have borrowed from social activists and is particularly appropriate if the goal is to defeat proposed legislation (Lord 2003). Constituency building can also persuade politicians that proposed legislation is losing popularity among the electorate (Keim and Zeithaml 1986). Opposition to public authorities will therefore be expressed by a coalition of interest groups that is dominated by private-sector agencies and that attempts to display grassroots support for its aims.

Second, innovation is a key to success in business political strategy, since competitors learn from history and can copy or counter strategies that have worked in the past (Fleisher 2002). Private-sector home health agencies throughout the country know of the SEIU, are aware of the tactics that it used to succeed in California, Washington, and Oregon, and are currently planning their response should the union try to establish public authorities in their states. The labor movement will only regain the element of surprise that gives it a competitive edge if it tries something new.

Finally and perhaps most importantly, there is a natural tendency for businesses that are the beneficiaries of existing institutional arrangements to fight hard to maintain the status quo (Keim 2002). Thus, the unions should expect a different and more intense challenge than they faced in establishing public authorities in the Western states. Employers can be expected to engage in “control rhetoric”, communications strategies aimed at defusing popular support for social change as expressed through social movements’ “agitation rhetoric” (Bowers and Ochs 1971).

Brimeyer, Eaker, and Clair (2004) apply the rhetoric of agitation and control to a union organizing campaign. They found that management used counterpersuasion, a control strategy aimed at convincing protestors that they are incorrect. Management also used two agitation strategies: polarization and sarcasm. If their results generalize to other arenas of labor-management conflict, the SEIU should anticipate that employers will employ “crossover strategies”, using agitation rhetoric to maintain control.

In this paper, I analyze employer responses to the New Jersey Quality Home Care Act. Had this legislation been enacted, it would have had the effect of steering all government-funded home health care to public authorities, thereby forcing an existing network of subcontractors out of business. I analyze employer reaction to this legislation to predict how employers will strive to maintain the status quo and to suggest counterstrategies for the labor movement.

The New Jersey Quality Home Care Act

The Quality Home Care Act was introduced into both Houses of the New Jersey State Legislature in June 2003. The current positions held by the Bill’s sponsors are Acting Governor, Senate Majority Leader, Speaker of the House, and House

Appropriations Committee Chair. Despite such high-powered support, the Bill died in committee and was not reintroduced in the most recent Legislative session. However, a Democratic victory in the upcoming gubernatorial election could revive this Bill's political prospects.

The proposed legislation divides the state into four regions and calls for the establishment of Quality Home Care Councils in each region. Each council would have nine members, appointed by the Governor, four of whom would be current or former home health care consumers. The Governor would retain veto power over any Council decisions within ten days, and this veto could not be overridden.

All qualified home health aides would join the region's referral registry. Initially, home health aides would be employed either by the region's Quality Home Care Council or by private agencies. Private agencies would be limited to spending no more than 25% of their revenues on administrative costs. When each Council feels ready to assume the administrative burden, all home health aides providing state-funded services in that region would become their employees. This legislation establishes a minimum wage of ten dollars per hour for home health aides, or nine dollars per hour with health insurance, whether they are employed by the Councils or by private agencies.

Consumers would have the right to choose any qualified provider. Consumers could hire their relatives who are not their spouses or (in the case of minors) their parents. While the precise details are left to each Council, the training requirements for relatives would be relaxed somewhat compared to non-relatives. Mindful of a recent scandal in New Jersey involving home health aides who had criminal records (Layton 2001), there

are four separate references to criminal background checks in the text of the legislation, and the background check requirement applies to both relatives and non-relatives.

Employees of Councils would have the right to bargain collectively should they choose to join a union. The bargaining unit would be the entire regional Council. They would not have the right to strike. They would, however, enjoy the rights of other employees in New Jersey with respect to occupational safety, nondiscrimination, and other relevant laws.

Analysis of Employer Strategies and Tactics

I use archival data to examine employer reactions to the New Jersey Quality Home Care Act. Archival data paint an incomplete picture of business political activity but have the advantage of objectivity (Schuler 2002). Specifically, I analyze an op-ed piece written by an opponent of the legislation, as well as an audio clip of a public hearing on the transcript of a public hearing on the New Jersey Quality Home Care Act held by the General Assembly Health and Human Services Committee.

The op-ed piece (Maddaloni 2003) is entitled “Bureaucratic nightmare in the making.” Its author is identified as a labor lawyer who represents home health agencies. This piece alleges that the New Jersey Quality Home Care Act “would destroy New Jersey’s well-established system for the delivery of home health care services, diminish the quality of home health care and provide a windfall to the SEIU.” The Act would “eliminate patient choice” because all home health aides would be employed in a “massive public bureaucracy.” Other flaws of the proposed legislation are that it “does not address training” and would leave patients with “no recourse if they were dissatisfied”.

The piece praises New Jersey's current system of home health care delivery. It alleges that aides have a median hourly wage of \$9.40. There is a great deal of accountability because the agencies have a "vested interest in the quality of care delivered by the aides." Scorn is heaped on the public authorities of California and Washington (though interestingly, no mention is made of Oregon.) Aides in Washington have low pay and few benefits, and the SEIU in California "recently agreed to return nearly \$5 million in dues improperly collected." California's state auditor recently concluded that public authorities are inefficient and ineffective (Maddaloni 2003). The following month, a rebuttal appeared in the same publication, systematically picking apart the arguments against the New Jersey Quality Home Care Act (Cohen 2003).

Maddaloni's (2003) essay displays ample evidence of the tactic of counterpersuasion, which is an important component of the rhetoric of control (Bowers and Ochs 1971). It also provides large doses of the agitation tactic of polarization. Polarization works if it succeeds in raising "flag issues" and identifying "flag individuals" (Bowers and Ochs 1971). A flag individual is an identifiable opponent, and a flag issue is a popular principle on which the opponent has allegedly taken an incorrect stance. The SEIU is portrayed as greedy opportunists, standing in the way of patient choice and minimum training standards. Except for the lack of sarcasm, this op-ed piece mirrors the tactics identified by Brimeyer et al. (2004) in their analysis of anti-union communications.

On the same day as Maddaloni's (2003) essay was published, the General Assembly Health and Human Services Committee held a public hearing on the merits of the New Jersey Quality Home Care Act (New Jersey State Legislature Archived Media

2003). The audio clip is very illuminating. Testifying against the proposed legislation were: the Presidents of two statewide industry organizations, three home health aides, several home health agency executives, high-level representatives from the Chamber of Commerce of Southern New Jersey, and a consumer. Clearly, the employers used the business political strategy of constituency building, which aims to convince lawmakers that proposed legislation lacks public support (Keim & Zeithaml 1986). The unified message provided by these speakers indicates a coordinated, well-planned effort, with the intensity that can be expected when businesses wish to maintain the regulatory status quo (Keim 2002).

Rhetorically, agitation and control are again apparent. As an example of counterpersuasion, several speakers offered inflated estimates of home health aide compensation. According to the Act's opponents, many home health aides receive benefits such as dental insurance and paid vacations, turnover rates are less than 20% per year, and labor supply is steadily increasing.

The use of polarization was somewhat different in the testimony as compared to the op-ed piece. Since nobody mentioned the SEIU by name and unions in general were infrequently discussed, there was little attempt to establish an identifiable opponent. A host of flag issues were raised. Opponents included every allegation in Maddaloni's (2003) essay, which underscores the sophisticated nature of the employers' campaign. In addition, they argued that the Act would eliminate the agencies' common practice of providing free home health care, take away home health aides' freedom to change employers, reduce the quality of supervision, and make it more difficult for clients to choose home health aides.

Conclusion

The arguments made by employers against the New Jersey Quality Home Care Act occasionally border on the ludicrous. For example, it is not at all clear how one's freedom to choose a home health aide is circumscribed by a law that allows clients to browse a complete list of eligible employees. On the other hand, the successful campaign to defeat this legislation is an example of the sort of business political strategy that the labor movement is going to have to counter if they wish to expand the use of public authorities to states where employers are profiting from the existing system of home health care delivery.

Statewide public authorities offer the best chance of resolving the home health care crisis. Because they equalize pay rates within a large geographic region, they are particularly beneficial to home health aides and consumers who live and work outside major cities and their suburbs. The labor movement will have to take the following steps to counter the storm of business political activity that they can expect to face in future home care organizing campaigns.

First, it is vital for the unions to stay one step ahead of the employer-led opposition. This has two components. They must predict the opposition's strategy and have a plan in place to deal with it. New Jersey's experience indicates that employers will utilize the rhetoric of agitation and control and the strategy of constituency building. The unions must also take innovative steps that catch employers by surprise. Employers' plans are based on the assumption that the labor movement will repeat the moves that it has made in previous states, so a lack of innovation will make it easier for employers to design and implement a successful counterattack.

Second, the unions appear to have a natural constituency with senior citizens and other home care consumers. As the AARP (2003) report indicates, the elderly are in no rush to move to nursing homes. Statewide public authorities can maximize the percentage of elderly and disabled individuals who live in non-institutional settings, because they maximize the supply of home health aides. They will need to portray the drive to establish statewide public authorities as the will of the people, in order to convince politicians to support it.

Finally, the agitation strategy of polarization appears extremely promising for the labor movement in this instance. The flag individuals would be the private-sector home care agencies. There is little love lost between consumers, workers, and the agencies in New Jersey. Considering that home health care is a service, the agencies appear to be surprisingly unresponsive to the concerns of consumers, who regularly gripe about the difficulties of finding a good agency and then finding a good aide. They also ignore their employees' demands for better working conditions and more respect (Mareschal and Bhatt 2005).

The villainization of private employment agencies is somewhat unfair, of course. They are products of a home health care delivery system that rewards low prices more than high quality. They do not appear to be in widespread violation of existing employment laws, chiefly because home health aides receive so little legal protection. However, private employment agencies and public authorities cannot coexist as equals. Therefore, the campaign for public authorities will have to paint a negative picture of the agencies in order to win public support for legislation that will drastically reduce the size and the scope of New Jersey's private home health care system.

The flag issues available to the unions are numerous. First, they need to note that home-based care affords a greater amount of dignity and a superior quality of life to eligible consumers. Personal appeals from home care consumers and their loved ones may be helpful in this regard. They should also explain how home health care is an extremely efficient use of tax dollars compared to institutionalization, and that a shortage of workers limits this program's growth. Virtually everyone favors dignity, quality of life, and cost-effective public services.

Proponents also need to connect the establishment of statewide public authorities to the concept of freedom of consumer choice. Consumers lack freedom of choice when there are no workers to be chosen, so consumer-directed care and improved compensation for home health aides are intertwined. A final flag issue concerns the right to a living wage. Home health aides can be effective as spokespeople for the public authority movement. They can talk first-hand about the caring services they provide and the substandard pay and benefits they receive.

There will be organized opposition to New Jersey's Quality Home Care Act if it is revived, and the owners of private home care agencies will undoubtedly lead it. The legislation is a direct threat to their business, as it allows each public authority to appropriate all federally funded home health care in each region whenever it deems itself to be prepared for this challenge. Notwithstanding the owners' cries of poverty, this is a profitable line of work because there is a large spread between the agencies' hourly reimbursement rates and the employees' hourly pay rates. A study conducted by the U.S. General Accounting Office (2002) indicates that Medicare's payments for full home care services were, on average, 35% higher than estimated costs. For example, National Home

Health Care (NHHC), a private sector business that provides home care services in New Jersey, New York, and Connecticut was recently praised in Fortune Small Business Magazine as a fast-growing, highly profitable small business. NHHC's net profits in 2001 were \$4.7 million. Medicaid accounts for approximately half of NHHC's revenue (Fortune.com-Small Business 100 2002). Furthermore, the provision of publicly funded home care services is a relatively low-risk business because the government never defaults on its payments, unlike some private clients.

The SEIU prides itself on being one of America's most forward-thinking unions. They may be the best-equipped labor organization in the country to deal with the task of expanding public authorities beyond California, Washington, and Oregon. It will be much more difficult to win in states which utilize private home health care agencies. The future of the home health care system may depend on the union's ability to succeed.

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