



Building a National Healthcare Workers' Movement

Saturday April 22, 2006

Executive Summary

For the first time in nearly half a century, there is serious, focused discussion both within our movement and outside of it, on how best to re-energize the labor movement. As part of the Service Employees International Union, the largest local union on the West Coast and the oldest health care workers' union in the nation, we in Health care have been strong supporters of the significant changes undertaken to revitalize our own International Union as well as SEIU's efforts to reinvigorate the national labor movement and build meaningful international solidarity through the creation of the Change to Win Coalition.

Specifically, we see our major responsibility as making SEIU the national union of health care workers in this country. Toward that end, we put forward for discussion this lengthy piece which draws on our experience as the collective leadership of Health care. The major conclusions of this document are set forth below:

1. The three primary work areas of the Union - organizing, collective bargaining and politics - are each equally important to building strength to win for workers, and success in each area depends upon success in the others.
2. Our ability to win bigger victories for health care workers and to reform the American health care system is contingent upon organizing and uniting more health care workers into our Union.
3. Health care workers (both public and private) are stronger when represented by a Union that unites health system workers and long-term care workers into a single Union.
4. Building a health care workers movement means taking a long-range, strategic, and industrial approach to health care that includes a real plan for fundamental health care reform and a real campaign to achieve it.
5. As our organizations become more complex, we must continue to build democratic internal union structures that give workers a real voice in the Union.
6. Diversity is fundamentally important, as are staff and elected union leaders who are representative of and accountable to the Union's membership.
7. Our role as Union leaders is to raise expectations for workers, including providing a progressive vision for unorganized workers and fighting for standards for members we already represent.
8. Our relationship with employers must be built at the foundation on a mutually respectful collective bargaining relationship that enhances the strength of the Union and does not compromise standards for health care workers. Efforts to build constructive relationships with Employers must not be confused with collusion that compromises our role as advocates' of workers' interests and independent guardians of the public's health care.
9. Our Union must move beyond simply the nuts and bolts of collective bargaining and evolve into a social and cultural center of our members' lives.

Building a National Health care Workers' Movement

As the nation's oldest health care workers union, SEIU United Health care Workers West, created in 2005 by the merger of SEIU Locals 250 and 399, has a seventy-year history of changing the lives of California's health care workers. Our union was founded by a group of orderlies at San Francisco General Hospital, the City and County of San Francisco's public hospital, in the aftermath of the 1934 San Francisco general strike and spread quickly into the Bay Area's private sector hospitals. In the 1950s, we began organizing nursing home workers. Through the 1960s and 1970s, the union organized more than a third of the nursing homes in Northern California. Since 1980 we have represented California homecare workers, and since the mid-1990s have organized more than 40,000 homecare workers in the In Home Supportive Services program.



“The victory is going to mean that we're going to have a say in safe staffing. The victory means that we got the education and training fund that CMPC has said many times that they wasn't even interested in. And for us to have the right to organize the unorganized is the biggest victory of all because I am hoping and I believe that from this day on CPMC will never want to face another strike.”

Helen York-Jones • Dietary Aide • 35 years of experience • Sutter California Pacific Medical Center

Part 1: Health Systems

The Sutter CPMC Strike in Historical Perspective

1.1 The Setting

The successful sixty-day strike in the fall of 2005 by 800 service workers at California Pacific Medical Center, the 1200-bed academic medical center owned by Sutter Health, the largest, most profitable hospital system in Northern California, provides an instructive prism through which to examine where we have come as a union and focus the vision of where we want to lead UHW and the labor movement in the next generation.

Any successful struggle, such as the strike at Sutter CPMC from September 13 to November 11, 2005, is the product of years of work. That work began in earnest in 1996 when we led the first serious coordinated bargaining campaign among acute care hospital workers in Northern California. Like many organizational advances, our enhanced focus on raising standards in acute care hospitals grew out of our inability to stop an employer offensive that came in this case, oddly enough, from Kaiser Permanente. In 1995 and into 1996, Local 250's failure to appropriately mobilize our members in Northern California forced us to accept a weak contract that included, for the first time in decades, wage freezes, takeaways in health insurance and retiree health care. Takeaways outside of Northern California, at SEIU Locals 49 in Portland, 105 in Denver, and 399 and 535 in Southern California, were even more extreme. For the first time in nearly a decade (since the lost 1986 strike), Kaiser bargaining in the mid-1990s marked a turning point: we were unable to make advances for Kaiser workers.

The situation was similar among all of Northern California's acute care hospitals. Defensive fights were required to stave off health insurance takeaways (at CHW's St. Mary's and St. Francis in San Francisco in 1994 and at independent Mt. Diablo in Concord in 1995), the right to honor picket lines (at then independent Summit Medical Center in Oakland in 1992) and to win wage increases that merely kept pace with inflation.

In 1996, we conducted our first concerted, coordinated campaign among Northern California's acute care hospital workers. Looking back, this beginning was rather modest. More by accident than through careful planning, 12 contracts covering some of our oldest and largest employers in the East Bay and the West Bay were lined up to expire between May and October of 1996. In preparation for bargaining, several issues were common among our demands of all our employers, most notably securing a ban on subcontracting.

Subcontracting as an issue had a profound influence on the 1996 campaign. In 1995, CHW had subcontracted out the linen services at its two San Francisco hospitals. As a result, the exact same linen workers who had been earning nearly \$14 an hour with fully employer paid health insurance for dependents as CHW employees, became employees of Angelica doing the exact same work in the exact same hospital for \$7 an hour with no benefits.

In an offensive fight, workers united to demand a ban on subcontracting. California Pacific Medical Center, strangely enough, was the first hospital to cave in, and afterwards, the other hospitals either fell into line or were struck in a series of one and two-day walkouts. The holdouts were Catholic Health care West and Sutter Delta. In mid-1996, many of the hospitals that are now central to the Sutter campaign were not yet affiliated with the corporate giant or had affiliated just months before. Those future Sutter hospitals included CPMC, Alta Bates Medical Center, Summit Medical Center, and Eden Medical Center. By unifying around a common set of issues and coordinating the campaign among rank-and-file leaders, we built an industry-wide hospital workers campaign that took on a fight for industry standards and won.

1.2 The Significance of the 1996 CHW Victory

In 1996, our most stubborn employer was Catholic Health care West. At the time, we represented approximately 800 CHW workers at three hospitals in San Francisco. Founded in 1986, CHW in a decade had grown into a 42-hospital system with nearly 40,000 workers. While the public fight with CHW in San Francisco spotlighted a ban on subcontracting, the 1996 agreement contained two other, arguably more significant, breakthroughs. The first was the unification of the CHW workers into a single master contract at the three facilities. Previously, three separate contracts covered workers at St. Mary's, St. Francis and Seton. Second, the agreement contained the first provisions in any Local 250 contract that circumscribed an employer's ability to campaign unfettered against unionization. In the three CHW San Francisco hospitals alone, more than

1,200 workers were unrepresented.

The victory at CHW was achieved through a series of rolling short-term strikes through the summer of 1996, as well as economic pressure from what would evolve into our current research department. During the summer of 1996, our research department published its first major analysis of the corporatization of the hospital industry in California. This document took the form of a popular education pamphlet designed to educate members about our changing industry and to generate support for the need to fight to organize more workers into our union. The 1996 contract campaign set the stage for our next round of bargaining in 2000.

1.3 The 2000 Contract Campaign

The 1996 contracts had four-year terms. Several significant developments occurred between the CHW settlement in the fall of 1996 and the beginning of the 2000 campaign.

- First, in 1997, with labor and management both acknowledging the resources wasted during more than a decade of constant conflict, we and seven other AFL-CIO international unions entered into a partnership agreement with Kaiser Permanente. The product of years of struggle, the Kaiser partnership established a different course for labor relations in the hospital industry in Northern California. The SEIU Local 250 contract with Kaiser had always been the gold standard in the acute-care hospital industry, even with the setbacks of the 1980s and 1990s. Indeed, the 1986 strike in which Kaiser successfully introduced two tiers of wages, separating its Bay Area facilities from the Central Valley and Sacramento, was a product of Kaiser's status as the lone unionized provider in a significant number of markets. The Kaiser partnership had an impact on the 2000 bargaining campaign in several ways: it established the standard that other hospitals workers wanted and were willing to fight for; because Kaiser had already agreed to it, workers viewed the goal as attainable; it demonstrated to the industry that there was a way to develop a constructive relationship with its employees; and it enabled the Union to focus its resources on employers like CHW and Sutter who maintained a more adversarial posture, especially regarding workers' right to join a union without interference.
- Second, as other hospital contracts expired between 1996 and 1999, Local 250 lined up even more expiration dates. By 2000 the number of contracts up for negotiations had grown to 24, more than double the size of the 1996 campaign.
- Third, in partnership with Local 399 and SEIU, we launched a full-scale campaign to unionize Catholic Health care West statewide, concentrating first on Sacramento and Los Angeles.
- Fourth, at the same time the campaign against CHW began, we escalated our comprehensive campaign against Sutter, in support of ongoing contract fights at Sutter hospitals and an organizing campaign among Sutter's visiting nurses in San Francisco. Finally, we conducted our first coordinated strike against Sutter when hospital workers at Sutter Delta, Sutter Solano and Sutter Roseville struck in July 1997. The simultaneous CHW and Sutter campaigns inaugurated the development of our comprehensive campaign capacity.

In preparation for the 2000 negotiations, rank-and-file leaders from 24 hospitals gathered in Oakland in July 1999 to develop bargaining proposals for our contract campaign. Leaders adopted goals of winning a real voice in staffing, employment and income security, improvements in retirement benefits and the right to join a union without employer interference. Rank-and file leaders represented CHW and Sutter facilities, as well as smaller independent hospitals like Chinese Hospital and Alameda Hospital, district hospitals like Washington and Salinas Valley, and public hospitals like San Francisco General and Alameda County Medical Center. At that meeting, rank-and-file leaders endorsed the bargaining goals and further agreed to create a rank-and-file bargaining council to serve as the steering/accountability committee which ultimately led the coordinated bargaining. Adding to our strength in 2000 were the 800 CHW workers in San Francisco who had been organized in the winter of 1999-2000 under the terms of the organizing agreement achieved in the prior contract. The campaign against CHW was further motivated by heavy, anti-union consultant campaigns that CHW ran against us in Sacramento and Los Angeles resulting in high profile election losses.

As in 1996, the 2000 bargaining centered primarily on CHW and Sutter hospitals. After months of bargaining with no hospital willing to accept our proposals, we struck ten hospitals for one day on July 6, 2000: three CHW hospitals, five Sutter hospitals, and two independent hospitals. In August, we staged a two-day strike. Prior to the strike, Alameda Hospital indicated it would agree to follow the settlement reached at CHW or Sutter and therefore was not struck. Within two weeks of the August strike, we reached a tentative agreement with CHW that resolved our core language issues, including third party resolution of staffing disputes. CHW then reneged on that agreement, which led to an intense escalation of the conflict. Repeated, coordinated strikes continued through 2000 and 2001 and, as more hospital contracts expired, either agreements were reached along the original

CHW pattern or these additional hospitals, like Tenet's San Pablo and Pinole facilities, were struck.

In February 2001, we settled the West Bay contract with CHW, paving the way for a system-wide organizing rights agreement in April. The repeated strike activity in the West Bay, later escalated with joint strike activity with SEIU Local 399 members at CHW's hospitals in Oxnard, was just one part of a major, comprehensive campaign against CHW. In that campaign - the product of more than four years' work with incredible focus - active organizing campaigns in Los Angeles and Sacramento put unorganized caregivers fighting for a union at the center of the campaign. Strong political support and support within the Catholic Church, through deep community organizing, also played a significant role in the CHW victory, as CHW became a poster child for bad corporate behavior regarding workers' right to organize a union. And finally, the larger research component of the comprehensive campaign, from fighting CHW's acquisition of hospitals, to blocking its attempts to divest hospitals like its Morgan Hill facility, to highlighting its abysmal charity care record, and more, combined collective bargaining, organizing and politics into a successful campaign.

The fight with Sutter continued through 2001 with two additional strikes and, by the fall of 2001, all the open contracts had been settled along the lines of the original CHW settlement. The Sutter agreements also included an organizing rights agreement modeled on the 1996 CHW West Bay contract for residual units, but not as strong as the new language achieved in the CHW system-wide agreement. Like the 1996 contracts, the 2000-01 settlements were for four year terms, once again setting the stage for the 2004 contract campaign.

1.4 The 2004 Contract Campaign

Developments between 2001 and 2004 reshaped and strengthened the 2004 campaign. The historic 2001 system-wide agreement with CHW led to the organization in 24 hospitals over the next several months. Unencumbered by a pre-agreement on contract terms, we were able to win uniform regional contracts that were unprecedented for first contracts: common expiration dates, a real voice in staffing, fully-employer paid health insurance for employees and dependents, and wage increases of as much as 68 percent for some classifications in certain regions of the state. The contract was as significant for what it lacked as much as for what it contained: there was no management rights clause. In their first contract, previously unorganized CHW workers won contract standards that their co-workers in the West Bay had fought to win for more than sixty years and struck repeatedly in 1988, 1994, 1996 and 2000 to obtain. For the first time, we were able to apply the higher standards of Northern California contracts as benchmarks for settlement of Southern California contracts.

Within months of the CHW settlement in 2001, unorganized Tenet hospitals throughout California extended fully-employer paid dependent health care insurance to their employees. With an escalating, SEIU-led comprehensive campaign that built upon the collapse of Tenet's creative financing schemes (specifically, Medicare's efforts to stop Tenet's receipt of outlier payments based upon exorbitant charges), Local 250 and Local 399 won a statewide election agreement with the nation's second largest for-profit hospital system. Similar to the breakthrough at Catholic Health care West, the agreement with Tenet resulted in the unionization of virtually every one of the chain's facilities in California. There was a significant difference, however, between the Tenet agreement and CHW's: along with terms of conduct for a representation election, the agreement with Tenet contained pre-negotiated terms and conditions for a first contract. The terms of that first contract were generally below industry standards, especially in Northern California, as it lacked wage scales, contained the right to subcontract, had no third-party resolution of staffing disputes, and other core provisions, while containing a comprehensive management rights clause. While the Tenet agreement gave the Union a significant foothold in the company, other differences, including interest arbitration of disputes over the initial contract and the first successor agreement, placed limitations on the ability of the Union to engage in more traditional means to build workplace organization.

In preparation for the 2004 bargaining round, more than 300 rank-and-file leaders gathered in Oakland in July 2003 to develop bargaining proposals for the industry-wide campaign. Leaders from Locals 121, 250 and 399, representing more than 50 facilities North and South united around a common set of bargaining goals.

Delegates ratified the major proposals: a real voice in staffing, the right to organize a union without interference, master agreements, common expiration dates, a training and upgrading fund, enhanced job security and retiree health insurance.

In the July 2003 meeting, we laid out our general strategy: our goal first was to win a single, statewide agreement with

Catholic Health care West that would serve as a pattern for additional hospital systems like the Daughters of Charity (which pulled out of CHW in 2002 and in which we represented four hospitals), along with independent, district and public hospitals. We also agreed that when the pattern was set, other hospitals would fight for the same standard and that we all needed to be prepared to strike for those standards. Furthermore, the responsibility for fighting for these standards did not end when a system or hospital settled. All agreed and understood that this was likely to end in a showdown with Sutter Health.

In fact, the bargaining campaign unfolded roughly as outlined in July 2003. We settled first with CHW, in a statewide master agreement that included for the first time in our Union's history a Taft-Hartley training fund, along with significant wage increases (matching industry leader Kaiser in most markets) and a re-opener in 2006 on retiree health insurance. Even better than we expected, we were able to extend the reach of the CHW agreement into Nevada, using our power in California to win the chain's agreement to remain neutral in the organizing campaign at CHW's St. Rose Hospital after months of misconduct and then to extend the terms of the CHW master agreement to Nevada workers, including the establishment of the first defined benefit pension plan for hospital workers in Las Vegas.

As we also expected, the Daughters of Charity settled next, with a master agreement settled less than 12 hours before a scheduled strike in October 2004, and the independent hospitals – Washington, Alameda, and Chinese – soon followed suit. To no one's surprise, the war was with Sutter.

1.5 The Sutter Fight

The situation at Sutter was different than at CHW and the Daughters of Charity. Unlike the CHW and Daughters of Charity contracts that had previously expired on the same date, the Sutter contracts expired in 2004 but not on the same date. The first contract at Alta Bates-Summit expired on April 30, while the last two contracts — at CPMC and Sutter Delta — expired on November 22. To be at maximum strength, we needed to work without contracts at Alta Bates-Summit, Sutter Eden, Sutter Lakeside, Sutter Solano, St. Luke's, and Sutter Santa Rosa as we waited for the CPMC and Sutter Delta contracts to expire. We also wanted to slow down the bargaining at Sutter to isolate them by reaching settlements everywhere else. And as an added complication, the Sutter fight was our first significant joint effort with the California Nurses Association since signing our alliance agreement with them in the fall/winter of 2003.

Our first major action was a one-day coordinated strike of 4,500 SEIU members at 8 Sutter hospitals (several hospitals, like CPMC, have multiple campuses) on December 1, 2004. The CNA, which had an open contract at CPMC and sympathy strike language at Sutter Solano and Alta Bates-Summit, struck with us at three facilities, adding an additional 2,500 striking registered nurses. Sutter responded by locking us out for an additional four days. Sutter rightfully understood that the single biggest strike issue was an organizing agreement. Leading into the strike, and particularly during the lockout, virtually every major public official in the communities that the hospitals served called on Sutter to settle the contract. Our public support, which was substantial to begin with, greatly increased in the aftermath of the lockout.

Assessing the strike and lockout, we came to the conclusion that limited, repeated strikes like those we staged in 2000-01 were unlikely to generate the settlement we were fighting for. Recognizing that the CNA's contracts at almost every Sutter facility where they were organized were scheduled to expire at the end of June 2005, we decided to hold contracts open in an effort to strike Sutter jointly with the CNA. In May, members at all our hospitals authorized open-ended strikes.

In mid-June we adjusted our timeline to the delayed pace of the CNA bargaining. We set a joint strike deadline of August 13. Prior to our delivering the 10-day notice, Sutter called and asked to meet simultaneously with all our hospitals and with CNA. Our bargaining occurred first and immediately went nowhere. To our great dismay, when Sutter gave the CNA last, best and final offers, CNA organized no opposition to the contracts from Sutter, despite formally recommending against them. By August 20, the CNA contracts were all settled.

We faced a choice. We could have decided to cut our best deal then. The likely result of that choice would have been to win common expiration dates, but give up on organizing rights, third-party resolution of staffing disputes, and a training and upgrading fund. We decided to fight on without CNA.

Throughout the Sutter campaign, leaders from our hospitals had met monthly, and sometimes more frequently, to help direct

the campaign. When we decided to strike in December 2004, that decision was processed through the Bargaining Council. The Bargaining Council also was the entity that decided to hold contracts open to coincide with the June 2005 CNA contract expiration dates. In mid-August we met immediately after the CNA settlements and unanimously agreed to fight on.

In the meantime, through an intermediary, the major Sutter hospital in the chain, California Pacific Medical Center, indicated that it was interested in trying to work out an agreement short of a strike. In mid-August, after the CNA settlements, we reached a tentative agreement with CPMC that it agreed to carry to the rest of the Sutter system in the form of a federal mediator's proposal.

Facing pressure from Sutter corporate leaders and from other Sutter hospitals, CPMC then reneged on the agreement. On September 2, 2005 we gave notice to strike all Sutter hospitals.

Between the time that we gave notice and the date that the strike was to commence, we realized that while the other Sutter hospitals were prepared for and even wanted the strike, this was not true of CPMC. Instead, while CPMC would no longer accept the mediator's recommended settlement, neither did it believe that its workers would strike. CPMC had misassessed the situation, and its initial agreement to the mediator's proposal for settlement had indicated some weakness and some level of autonomy from Sutter. These factors, combined with the belief that San Francisco was, politically, our strongest place to wage a fight, led the UHW leadership to recommend a strike against CPMC alone.

On September 11, we gathered our Sutter leaders together and laid out our plan to strike just CPMC. First, CPMC had initially accepted the federal mediator's proposal. Second, by doing so, CPMC had indicated it wanted to avoid a strike. Third, we were strongest politically in San Francisco. Fourth, the CPMC workers were the most prepared to strike. Fifth, if we broke Sutter at its largest most profitable hospital, it would be easier to break them at the others. After a vigorous two-and-one-half-hour debate, we agreed to strike just CPMC.

The sixty-day strike was the most successful strike in the history of our union and established the identity of the new SEIU United Healthcare Workers West as a fighting, winning organization. It was the first open-ended strike our union had staged in a hospital since Summit in 1992 and, before that, since the San Francisco Affiliated Hospital strike in 1988. From the time the strike started to the end, the number of striking workers actually grew. We were stronger on day sixty than we were on day one. Before the strike, we had eighteen stewards at the three campuses. Today, we have more than fifty stewards.

The success of the strike was due first and foremost to the solidarity of the workers, more than ten years in the making, but other factors contributed significantly as well. Just as the strike was commencing, we settled the national Kaiser agreement, again highlighting the dramatic difference between Sutter and the rest of the industry. Financial support from the SEIU Health care Division and the 1199 national strike fund, which UHW had recently joined, enabled us to offer strike benefits of \$400 a week and, for the first time in our union's history, to blunt the employer's threat to cut off workers' health insurance benefits. Our size, our history, our engagement with the City and County of San Francisco through our public sector health care and homecare members, and our overall strong participation in San Francisco politics also combined to generate enormous political support for the strike. Aaron Peskin, the President of the Board of Supervisors, played a crucial role by using his office as a bully pulpit and a pressure point to continually confront Sutter with the complications it would face when it sought approval of its pending \$1 billion hospital construction project. As the strike drew longer, Peskin was preparing to convene a public hearing specifically to discuss the shape of a San Francisco health care delivery system that no longer included any Sutter facilities.

Finally, while virtually all of San Francisco's public officials had long supported the workers' demands, their support intensified as workers were fighting for the union on the picket line. This support culminated in U.S. House of Representatives Democratic Leader Nancy Pelosi's direct intervention in negotiations, as she personally mediated the thirteen-hour Sunday bargaining session that resolved the strike issues.

This cumulative pressure, including the participation of dozens of senior and disability rights groups, low-income advocacy groups, environmental justice and affordable housing groups, and congregation-based community organizations, along with the relentless picketing of hospital board members, finally forced CPMC to settle. As a result, today we are in the midst of organizing 2,000 residual workers at CPMC, and have since settled all but two Sutter contracts. Contracts at Sutter Alta Bates Summit Medical Center in Oakland and Berkeley, Sutter Delta in Antioch and Sutter Solano were settled without

strikes, winning the pattern set at CPMC, including organizing rights for an additional 1200 workers. An election for a small residual unit is already scheduled for Sutter Solano post settlement. When Sutter's management at Sutter Eden balked at the settlement, workers there struck for a week, were locked out, then ultimately settled for the CPMC settlement. Negotiations continue at Sutter Santa Rosa and Sutter Lakeside.

1.6 Conclusions from the Sutter CPMC strike

One immediate consequence of the Sutter CPMC strike is our need to more fully integrate Tenet, HCA and the independent Southern California hospitals into the coordinated campaign calendar in 2008. Where in Northern California, with little effort, a standard won at CHW will be applied to the Daughters of Charity and other independent hospitals, that level of integration does not yet exist in Southern California. Bringing Southern California hospitals like Cedars Sinai and Providence St. Joseph's in Burbank up to industry standards will not just produce immediate improvements for the workers at those hospitals. It will raise expectations for the thousands of unorganized hospital workers across Southern California who are employed outside of our major chains. To accomplish this, our first 2006 Bargaining Council meeting was held on March 25 in Los Angeles with nearly 200 acute-care hospital leaders from across the state engaged in preparation for the upcoming negotiations.

The Sutter CPMC strike also points toward some important conclusions about: (1) setting industry standards and taking an industrial approach to employer relations based on strength and struggle; (2) the role of rank-and-file leaders in the real decision-making of the union; (3) the importance of significant worker engagement as a core component of any comprehensive campaign to win organizing rights; (4) the aggregate political power derived from being a local union that represents both long-term care workers and acute care hospital workers; (5) defining the role of a lead local in SEIU; (6) and our vision in UHW for rebuilding the labor movement.

Part 2: Long-Term Care

The Long March Toward Dignity, Rights and Respect

2.1 Nursing Homes: The First Steps Forward

Just as Local 250 pioneered the organization of hospital workers into SEIU, the organization of long term care workers was also a major program of the Local – and one in which we had achieved significant success – long before it became a primary focus of the International Union.

Beginning in the early 1960s, after a landmark NLRB decision determined that workers in proprietary (for-profit) nursing homes were covered by the National Labor Relations Act, Local 250 successfully launched a massive organizing campaign among nursing home workers in Northern California. The establishment of Medicaid in 1965 sped the growth of the nursing home industry (and before the backlash against state budget growth put an end to California's cost-plus reimbursement system), and Local 250 followed that growth.

By the late 1960s, Local 250 had successfully organized its core nursing home membership. Building upon its public sector nursing facilities, Laguna Honda in San Francisco and Fairmont in Alameda County, the Union achieved density of approximately 80% in the Bay Area and 35% throughout Northern California among numerous independent operators, small regional chains and the emerging national chains that were just taking shape. This industry strength along with our aggressive bargaining efforts enabled us to achieve what were, at the time, the nation's best standards outside of Connecticut and New York. These standards also drove the non-union portion of the industry to match them.

To be sure, Northern California nursing home workers remained just one step above poverty and well shy of parity with unionized hospital workers doing the same jobs, while contract expiration dates and standards remained varied among different employers and across geographies.

However, over these years, Local 250's nursing home members, with the full support of the Union, made meaningful economic progress based upon strong organization and serious struggle, and also achieved some sorely needed control over their onerous conditions of work – a measure of the dignity, rights, and respect that nursing home workers want above all else. As the seventies drew to a close, the broader political, economic, and industrial conditions that had enabled this progress – difficult and uneven progress, but progress nonetheless – changed for the worse.

2.2 Flat Rates, National Chains, and Coordinated Campaigns

The same fiscal and political pressures that contributed to the infamous passage of California's Proposition 13 in 1978 and the election of sixteen years of Republican governors beginning in 1982 had an affect on the long-term care industry: the imposition of a flat rate reimbursement system for California's nursing homes. This flat rate system paid every facility in the same "peer group" the same rate regardless of its expenditures on wages, benefits, and staffing. Its effect created iron clad incentives for union avoidance, holding down workers' standards, and increasing profits by reducing costs. Soon after, in California and across the nation, efforts at nursing home industry consolidation began in earnest, resulting in an ever-changing slate of multi-state and nationwide chains attempting to generate profits by achieving economies of scale and standardization.

Chains occupied different niches. Some remained mostly custodial, while others focused on capturing more lucrative residents needing rehabilitative care paid for by Medicare and private insurance. Some providers were intent upon using their facilities as platforms for marketing specialty and support services to other providers, while others sought to profit from complex real estate investment schemes.

The most ambitious nursing home chains with the longest view to the future even began to position themselves, precociously, to compete for contracts from third-party payers and to prepare for the ultimate imposition of Medicaid managed care.

In this climate of intensified employer opposition, where any ground gained by workers came directly at a cost to provider,

and when heightened competition and aggressive growth strategies destabilized the industry, Local 250 joined in the emerging efforts of the International Union to coordinate approaches and implement best practices across the nation.

For organizing and bargaining, this meant that we focused our efforts on coordinated campaigns, conducted alone and with other Locals, like Local 399 and Local 22, within and across state lines, against targeted national chains. Politically, this meant that the Local focused its efforts on dedicated wage pass-throughs and regulatory measures designed to raise the floor of standards for workers and residents alike, while reducing the relative cost to employers of accepting the union.

These attempts at national coordination across the nursing home industry were for many years the strongest and most successful of SEIU's efforts to function as an industrial union. Despite these efforts, they ultimately ended in a stalemate.

We retained the strong support of our members and displayed time and again our ability to mobilize in struggle, in wave after wave of confrontations with different industry giants. However, while the union stayed strong and held its ground, it did not grow significantly and did not achieve dramatic progress on standards. While certain national chains sustained significant damage and were driven to significant retrenchment or full retreat, other national and regional players arose quickly in their place, and none acquiesced to a significantly better constructive relationship with the union on any grand scale.

The long and difficult Hillhaven bargain-to-organize campaign and strikes of the mid-nineties marked an end to this era in California and forced a radical rethinking of our strategy on how best to deploy our members' strength to produce fundamental change for them and the residents they serve.

2.3 Homecare: A Different Path to Progress

While the nursing home industry and the Union were mired in trench warfare that highlighted for California's elected officials and opinion leaders the serious deficiencies of institutional care, the Union was aggressively pursuing another avenue in its efforts to remake the long term care system. Over the course of the early 1990s, after Local 434B and the International Union's initial, unsuccessful efforts to secure the recognition of Los Angeles County IHSS providers as public employees, Local 250 was at the forefront of SEIU's efforts to establish an employer of record for IHSS independent providers.

Local 250 has represented 500 agency-based San Francisco homecare workers since 1980 and eagerly joined Local 434B, the State Council, the International Union, and homecare advocates in developing the Public Authority model. This innovative, quasi-governmental entity that empowered consumers to direct their services while enabling IHSS workers to organize and collectively bargain their wages and benefits has since been copied across the nation.

Although many argued (and continue to argue) that county employees' unions holding the most comfortable relationships with county supervisors would be best suited to win the investments of county dollars necessary to leverage improvements for IHSS providers, it is UHW and its predecessor Local 250 that have won the most landmark achievements in this field, including:

- Among the first Public Authority ordinances establishing an employer of record for IHSS providers;
- the first Public Authority contract (San Francisco);
- the first investment of county funds over and above the level for which the state will pay its share of cost;
- the first health care benefits, dental plan, vision plan, and pension; and
- the first supplemental wages in lieu of paid time off.

UHW's aggressive advocacy, mass mobilization of members and sophisticated intervention in dozens of local electoral, legislative, and budget fights have produced first contracts without fail and standards that meet or exceed the state match throughout the Bay Area and beyond. Only in the low wage, high unemployment, predominantly agricultural counties of the Central Valley and the Alpine Region have second-tier contracts been settled.

The same active engagement of members and strategic capacity that produced these results on a local level was critical in driving the policy development and political struggles necessary to establish and grow the state share of cost for IHSS

wages and benefits above the minimum wage. Indeed, in partnership with Local 434B, UHW has led SEIU's California homecare organizing, bargaining, and public advocacy and has pioneered the strategies and tactics critical to its success.

Even with the critical role homecare workers played in "labor friendly" Gray Davis' gubernatorial election, it was only after a full court press, culminating in a Local 250 protest at the 2000 State Democratic Convention, that ongoing increases in the state share of cost above the minimum made it onto the table. And once such improvements were on the table, UHW policy staff played a critical role in designing the funding stream enshrined in the Aging with Dignity Act.

UHW and Local 434B have also driven the policy work, communications efforts and grassroots lobbying required to secure additional funding for IHSS wages when improvements were not triggered by state revenue increases and to fight off Governor Schwarzenegger's attempts to cut IHSS wages and benefits back to the minimum.

Now more than ever, as legislative authorization for increases in IHSS state matching funds is exhausted, it is critical that UHW and Local 434B retain their leadership role in this sector. It is these two anchor Locals, one North and one South, that have consistently produced the greatest membership participation in support of IHSS funding and have the most political capacity in the field.

2.4 Closing the Circle

In a virtual circle, just as the battle to secure a state funding stream for IHSS improvements was coming to a close, the Union was able to use the new power and credibility derived from its homecare work and acute-care hospital bargaining and organizing campaigns to help drive reform of the state's nursing home reimbursement system.

The nursing home strike wave of the mid-nineties and its failure to produce major breakthroughs in organizing and standards had led Local 250 leadership to believe that no major gains would be possible in this sector without a complete overhaul of the perverse incentives in the state financing system. Efforts toward such an overhaul had been made before, in 1990, when State Senator Henry Mello, a long term care pioneer, sponsored SB 1087, a bill with both union and industry support that anticipated significant aspects of the reforms ultimately achieved more than a decade later.

In 1998, with the election of a Democratic governor for the first time in sixteen years, we and the State Council recommitted ourselves to change the nursing home reimbursement system as necessary to spur growth and standards. The Union pursued a renewed and refocused strategy to win wage pass-throughs, staffing improvements, and regulatory reforms as stopgaps while a rate study was performed to prepare a new reimbursement system. This effort was driven by high quality research and communications work regarding conditions in the California nursing home industry and grassroots and Capitol lobbying on an unprecedented scale.

The Union's new focus first bore fruit in dedicated funding for increased compensation in both 1999 and 2000, which, along with a tight labor market, brought workers their first major wage and benefit improvements in nearly a decade. These wage pass-throughs also produced a critically important side benefit by demonstrating how much of the money never made it into workers' pockets and dramatically illustrating the need for greater accountability and better incentives in the rates. As a result, in 2001, nursing home rates were virtually frozen, with money available only for the Wage Adjustment Rate Program (WARP), a supplemental payment to facilities that contractually guaranteed wage and benefit improvements to their workers. Furthermore, the passage of AB 1075 in 2001 accomplished the other initial goals of the strategy by improving staffing standards, tightening nursing home regulations and mandating the implementation of a facility specific rate system by August 1, 2004, subject to federal approval.

Also at this time, the small number of nursing home workers represented by SEIU in Southern California were transitioned out of Local 399 into Local 434B, setting up the leadership structure for SEIU's long term care work in the state that remains in place today. The two Locals and the State Council, with technical assistance from International staff, then began working in earnest on a detailed proposal for rate reform, aimed at producing an up-to-date, cost-based reimbursement system with strong incentives for higher spending on wages, benefits, and staffing.

The nursing home industry had previously stated a preference for an acuity-based reimbursement system, but as rate development discussions began in 2002, they immediately showed openness to the union's reform proposal. This was

prompted in part by the proposal's merits, in part by the state's elimination of the nursing homes' COLA for the previous year, and in part by the financial straits of the industry in the face of declining Medicare reimbursements and debt-driven bankruptcies.

The Union's reform proposal quickly became the policy document of reference and the basis for a renewed dialogue with the industry, in line with the direction of the International Union.

2.5 An Uneasy Alliance in Nursing Homes

In the spring of 1998, as bankruptcies of national nursing home chains mounted and California's stingy Medi-Cal system left operators with among the lowest margins in the nation, the state's nursing home association, the California Association of Health Facilities, invited UHW President Sal Rosselli to address its quarterly membership meeting.

Rosselli communicated to the nursing home operators two simple principles and one simple proposition. The union sought to advance quality care for all nursing home residents and quality jobs for all caregivers by uniting all nursing home workers in one union and taking work standards out of competition. The union understood that in order for caregivers and residents to prosper, the nursing home industry must receive higher reimbursements and achieve reasonable margins, and must do so dependably. The union offered to work together with the nursing home industry to achieve these mutually beneficial goals, with only one condition: the industry must recognize the union's right to exist and allow nursing home employees to choose to join the union without employer interference. The nursing home operators listened, were bemused by Rosselli's proposal, and went on about their business.

A little more than three years later, after one gubernatorial election, two wage pass-throughs, the rate freeze, the WARP, and a regulatory reform bill, the industry was finally ready to talk. Led by Long Term Care Division Director David Kieffer, who had developed significant new relationships with employers at the national level, including several with a major presence in California, UHW and Local 434B joined the International Union in an effort to create a strategic alliance with California's nursing home industry.

The premise of the dialogue between the parties was to structure an agreement that would facilitate the pursuit of their common goals of improved care for residents, improved standards for workers and improved finances for operators. Employers would tolerate union organization as the catalyst for their workers' political mobilization and other union investments in support of these goals. However, from early on it was clear that the extent of the employers' tolerance for union organization was very limited and that fundamental change in the parties' relationship would be hard to achieve. The participating nursing home operators insisted that the initial phase of the relationship must prove that the union could "add value" for their business purposes with little if any downside risk to them.

Concretely, as it took shape in the fall of 2002, the "Alliance" agreement meant that:

- relatively few facilities out of hundreds in the Alliance and 1,300 statewide, would be opened to unionization up front, with no clear path to organization of all the Alliance facilities, but only limited additional neutrality to be granted upon the completion of major policy objectives including reimbursement reform and liability reform;
- there were no successorship protections for the union rights and standards of Alliance employees with collective bargaining in the event of facility sales, in contrast to the strong successorship language incorporated into the Tenet corporate agreements that protected the Union when Tenet sold 18 California hospitals;
- almost all of these new facilities – 26 out of 30 – would be covered under a "template" agreement that memorialized all current management rights and policies, allowed grievance arbitration only upon discharge, and maintained bargaining unit compensation at its pre-existing share of Medi-Cal revenue, with no clear path to dissolution of the template, commencement of a broader collective bargaining relationship, and the achievement of significant progress toward wage and benefit parity with acute care workers in comparable jobs;
- the union would have access to workers in unorganized Alliance facilities only for mutually agreed upon purposes, carrying mutually agreed upon messages and materials, and would be barred from talking about the union, much less organizing, at any Alliance facilities except those explicitly opened up to unionization;
- there was no clear path to transition from single facility and single employer agreements to a multi-employer master contract, another core objective of the union.

Rather than expressing a new, principled alliance of the union and the nursing home industry around a set of ongoing, shared interests, this agreement was purely transactional, representing a set of situational, quid pro quo exchanges to be followed by others in the future.

The union, anxious to engage the industry in any manner, hungry at the prospect of even limited growth, and without regard to the exercise of power that got the employers to the table in the first place, accepted the current Alliance agreement in the absence of an immediate, superior alternative. Despite all indications to the contrary, our naïve expectation, expressed to the employers, was that this agreement marked only a transitional phase in our relationship that would allow the parties to establish a track record of good faith collaboration and positive experience in working together. We believed that, ultimately, the success of our common labors would open up all Alliance facilities to unionization and allow the full scope of collective bargaining for Alliance workers.

The employers suffered no such illusions and at the turn of 2003 put us straight to work. We first corrected the few elements of our rate reform proposal that did not maximize the employers' interests, then fought off proposed Medi-Cal cuts of 15%, even winning a COLA and neutrality at several more facilities through an unprecedented public campaign.

The next year, our low expectations and high anxiety caused a serious blunder, when the frantic search for a tit-for-tat exchange to yield further neutrality led us, in light of Governor Schwarzenegger's election, to prioritize the value of liability reform while de-prioritizing the value of rate reform. We agreed that the achievement of liability reform would yield 50 facilities to neutrality, while the achievement of rate reform would yield only 10. As a result, when we actually passed AB 1629 and achieved rate reform in the 2004 legislative session, we injected a minimum of \$900 million into the nursing home industry over a four-year period with very little to show for it. Meanwhile, we remain hard pressed to achieve liability reform as the only currently agreed upon avenue to win significant additional neutrality.

In the fall of 2005, we entered bargaining simultaneously with the implementation of the AB 1629 rate system, which pays higher rates to facilities that provide better wages, benefits, and staffing, and has more flexibility and lesser lag time in reimbursing costs than almost any other state. Contrary to the "non-zero sum" nature of the new rate system and early indications that Alliance members would change their economic behavior to match its logic, negotiations soon reverted to form, with employers arguing over the implementation of outmoded economic formulas unsuited to their interests, not to mention ours.

Currently, after months of frustration, delay, and reluctance on our part to risk the relationship, we have been whittled down to the minimum acceptable settlement, less than we could have achieved through yearly wage pass-throughs and arguably, in many instances, even less than required by the template agreement. Still, it is enough to mark meaningful progress for all our members, to create stronger and more uniform standards in most of Northern California, and to raise out of abject poverty our worst paid nursing home members in Southern California and the Central Valley.

The lesson of the Alliance experience to date is not to abandon efforts at collaboration with nursing home employers, but not to let our desire for the relationship place us in a position of weakness that relinquishes the substantial power we have. In the wake of the Alliance settlement, we have an opportunity and an obligation to hold the rest of our current employers to the Alliance standard and to organize aggressively in Los Angeles County and other strategic areas of the state where our gains will outpace those of non-union employees.

We also have the opportunity and the obligation to begin rectifying what's wrong with the Alliance agreement when it reopens next year, and we must use our strength to do so. The sunset of the AB 1629 rate system in 2008, the push toward long term managed care, and the threat of federal cuts in Medicare and Medicaid set the stage for us to secure commitments for a clear path to full neutrality, full collective bargaining, and a multi-employer master contract. It will take the full involvement of our members and the full deployment of our political power to do so. We must not be foolhardy, but we must also not be afraid to use our power to change the Alliance relationship so that it serves to unite California's nursing home workers into our Union and meets its promise to improve standards for caregivers and residents alike.

2.6 Writing the Next Chapter

This brief overview of the decades long, deliberate and painstaking progress of SEIU's long term care work in California demonstrates that UHW's strategic leadership of the Union's organizing and bargaining efforts in this sector has been integral to their success and has poised the Union on the brink of a breakthrough. Having built a critical mass of homecare workers throughout the state and won a nursing home reimbursement system that can underwrite unionization and improvements in standards, we, together with our partners at Local 434B, face several critical tasks necessary to fulfill our promise:

1. We must build a broader, deeper, and stronger organization of our members that will allow them to hold the state, counties and employers accountable to make good on the promise of the existing homecare and nursing home systems. This includes achieving mature, constructive relationships with employers based upon mutual respect and principled alignment of core interests rather than episodic bartering for short-term gains.
2. We must, in addition to pursuing strategic alliances with employers where possible, mount strategic campaigns to punish recalcitrant employers and organize their employees to demand the standards achieved in the unionized long term care sector.
3. We must work to "rebalance" and fill the gaps in California's publicly financed long term care system, which does well for those needing only personal assistance services, and should soon do well for consumers requiring institutional care, but does not do well for consumers whose needs fall in between. This work includes developing a pro-worker and pro-consumer path toward integration of acute care and long term care that builds new residential care options and home and community based services from the ground up and leverages our health systems employers to organize the home health sector. Our capacity to work effectively in the integrated systems of the future favored by state and federal policy makers will depend significantly upon our ability to coordinate across all health care sectors in the same union.
4. We must utilize our training and upgrading capacity to maximize caregivers' job opportunities by building vertical and lateral career ladders that help meet the changing needs of consumers and employers while building stronger links to other health care sectors in order to help leverage organizing and bargaining opportunities.
5. Finally, we must attempt to organize the army of private pay personal care assistants by winning authorization for IHSS services to be offered on a private pay basis and exploring the creation of an associate member category for these workers. Benefits of membership could be access to the services and discounts already available to SEIU members, group health insurance, registry and referral services, and, most importantly, the unions' training programs.

These are tasks that UHW's seasoned leadership, interdisciplinary skills and cross-sector capacity make it uniquely suited to address: to deal with the extraordinary complications of proposals for long term care integration, to leverage hospitals and health systems' roles as principal providers and sources of referrals for home health care, and to develop new intermediate residential care options.

Ultimately, our capacity for change and progress hinges first and foremost upon our ability to unite our members, across all health care sectors, in pursuit of a health care system where all workers have good jobs, comparable work earns comparable standards, and all consumers receive quality care. This unity among health care workers in pursuit of good standards, parity, and quality care is what will generate the focus and the commitment needed to achieve our Union's goals, by growing our numbers and building the power necessary to change the lives of our members and the people they serve.

We also know that to build and maintain a just health care system, we must ensure that consumers receive the most appropriate care in the most integrated setting possible and that providers be reimbursed sufficiently to deliver dependable, quality services in a financially sustainable manner.

These imperatives call for a comprehensive strategy, utilizing the most advanced campaign tactics but rooted in the desires and the participation of frontline workers, seeking common cause with employers while articulating our own particular interests, and seeking realistic but meaningful progress to build our capacity for fundamental change.

Part 3

Industry Standards, Employer Relations and Their Role in Union Building

Because of our size and our history, we have a wide range of experience in every mode of employer relations. We are part of perhaps the country's most innovative labor-management partnership with Kaiser Permanente, whereas with Sutter, we have one of the most adversarial relationships between a union and a health care employer anywhere in the United States. And we have dozens of relationships that fall between those two extremes. Central to each of those is the role of collective bargaining.

3.1 The Partnership: Kaiser

Created in 1997, our partnership with Kaiser grew out of more than three decades of strikes and adverse relations with the health care giant. Already mentioned above were the 1986 strike and our huge fights with Kaiser in the mid-1990s. Preceding even those struggles, were Kaiser strikes in 1969 and 1973. The partnership was also created with an employer that was already, at the time, more than 70% unionized. Today it is more than 80% unionized.

Through the partnership, we have truly made Kaiser the employer of choice in markets throughout California and beyond. The 2005 National Agreement sets the standard for hospital worker contracts throughout the United States. For the first time, key standards won in California were extended to SEIU locals in Oregon and Colorado.

And we have learned important lessons from the Kaiser partnership, especially regarding the Kaiser employees' relationship to the Union.

Daily, we are faced with building union consciousness among thousands of workers who have little or no experience of having to fight to improve wages or benefits in the workplace. In 1986, we struck Kaiser with 8,000 workers. Today we represent 38,000 in UHW alone. Of those 8,000 workers who struck in 1986, less than 1,500 are still employed at Kaiser. That means approximately 36,500 Kaiser workers represented by our Union have not experienced a major struggle with Kaiser to improve wages and benefits.

At its core, the Kaiser partnership means incorporating the union into the employer's major decision-making processes. This involves top leaders of the union working jointly and collaboratively with top leaders of Kaiser (though less so with the Permanente Medical Group) down to a hospital unit level where rank-and-file union members work constructively with front line managers. Legislatively and politically, we have worked together with Kaiser to coordinate our interests, such as our mutual support for Proposition 72. Just as importantly, when our interests don't align, we have generally been able to work through those differences or minimally take measures to offset potential detrimental effects to one side or the other.

Currently, every Union steward is permitted a minimum of eight hours of paid time per month for union training and education. Our new contract also provides for 24 full-time union directed rank-and-file leaders to help administer the contract, paid for entirely by Kaiser. The strongest rationale used to justify these positions was that the contract administrators would free other union staff to help organize Kaiser's competitors. In addition to a ban on subcontracting, Kaiser also agreed to "in-source" work that is traditionally done by SEIU members. In Northern California, we were able to eliminate two-tier wages between the Central Valley and the Bay Area, reversing the outcome of the 1986 strike. The 2005 Kaiser contract also begins to bridge the gap between Northern and Southern California wages and for the first time in history, provides uniform, minimum across the board increases for SEIU members in California, Colorado, and Oregon.

The day-to-day realities of the partnership are complicated. In an organization of Kaiser's size, the levels of cooperation are not uniform, but generally there is a healthy respect for the Union. The premier example of the union-building potential of the Kaiser partnership is Kaiser Fresno where we represent approximately 900 members. There are over 70 stewards. Members in Fresno have a great appreciation for Kaiser as an employer and they love the union. There is not a permanent staff person assigned to the facility. Grievances are minimal and are resolved quickly. There has not been an arbitration at Kaiser Fresno for years. More recently, the partnership has undertaken joint initiatives to improve patient care quality at the Kaiser Fresno facility.

Kaiser's contract standards — high wages, great benefits, a role in decision-making — have made Kaiser an inspiration for workers at Catholic Health care West, Sutter and other providers in their contract struggles. Workers at Sutter and other chains also understand that our success at Kaiser is because Kaiser is almost entirely unionized and is the direct result of representing 38,000 workers who bargain at a single table with 42,000 other Kaiser workers. The Kaiser example makes organizing rights an issue that other hospital workers see is worth their struggle in pursuit of their own best interests.

Over the past several years, we have also worked hard to educate Kaiser workers about their interest in helping to organize Kaiser's competitors. For example, as a side letter to the 2000 agreement, we agreed that in any geography where we had organized more than fifty percent of a market that was in the second tier of the wage structure, Kaiser would re-open the contract to discuss the elimination of the second tier.

In short, the Kaiser contract has provided an inspiration for non-union workers to organize the union and an incentive for Kaiser workers to support the organization of its competitors.

3.2 Strategic Alliance With Workplace Power: Catholic Health care West

If Kaiser is the employer with whom we have our most positive relationship among hospital systems, Catholic Health care West is close behind. Like Kaiser, our relationship with CHW was born of struggle, a struggle with a system that was in the midst of a profound transition.

The first five years of our relationship have consisted of our collectively transforming what had been an extremely contentious, adversarial relationship into one based on mutual respect and cooperation. Since the corporate-wide agreement was signed with CHW in April 2001, we have successfully negotiated two rounds of contracts, including our first statewide master agreement, covering three SEIU Locals, without a strike. Shortly after the 2004 settlement, we negotiated a neutrality agreement with CHW for its hospitals in Las Vegas, and within months of successful elections, extended key terms and conditions of the CHW California contract to the Las Vegas market.

In contrast to the partnership at Kaiser, the day-to-day labor relations at CHW are more traditional, but generally not adversarial. While our agreement contains no restrictions in our ability to leaflet, sticker, organize marches on the boss, conduct an informational picket or other more traditional union activity, over time a protocol for resolving disputes has emerged. Stewards receive four hours of paid time per month for Union training, and every CHW facility has conducted joint labor-management training on issue resolution. Before leafleting or before workers begin airing issues publicly, managers are given every opportunity to correct problems. From a union organizational standpoint, this protocol has balanced the competing demands of collaboration with the employer versus building a culture of struggle in our facilities. Because our hands have not been tied when faced with a recalcitrant manager, director, or even hospital president, we have been able to defend the interest of workers in a way that validates the power of the union. On the other hand, the healthy respect that CHW has demonstrated for its unionized employees has made it unnecessary for workers to dread coming to work to face an adversarial workplace in a constant state of warfare.

At a corporate-wide level, considerable progress has been made to coordinate and align CHW legislative and political work with our own. CHW, like Kaiser, was a strong supporter of Proposition 72, and we have begun to work together in San Francisco, Los Angeles and Sacramento counties on issues of hospital construction, expanding access to health care, and promoting strong partnerships with public health care systems.

More recent developments with CHW provide an opportunity to take our relationship with CHW to a new level. Consistent with the National Labor-Management Project in development by the Health care Division, several CHW hospitals would be strong candidates in a national project to work constructively with health care providers to improve quality care, patient satisfaction and employee satisfaction.

3.3 Strategic Alliance With Restricted Workplace Power: Tenet

Similar to Kaiser and Catholic Health care West, we have a system-wide agreement with Tenet, the nation's second largest

for-profit health care system. But the differences between our relationships with Kaiser and CHW our relationship with Tenet are fairly significant.

We have recently begun to meet with Tenet to begin the process of coordinating (where possible) political/legislative work. That work, in its infancy, is comparable to initiatives with CHW and Kaiser.

It is in collective bargaining that the differences are most pronounced. Unlike Kaiser and CHW, SEIU and Tenet do not have a pre-existing history of struggle. Although our Union has represented a Tenet hospital since 1969 (which was one of the numerous hospitals that Tenet divested in 2004) until recently there was not an active engagement at a corporate level.

A product of a relatively short comprehensive campaign led by the International Union, the Tenet agreement was also a by-product of a scandal-ridden company in the throes of collapse.

While the Tenet agreement provides a foothold for building a real union at Tenet, several features of the agreement have restricted our ability to make progress. To begin with, the model contract provisions and the Board of Inquiry process without a right to strike for resolving the first contract tended to diminish the role of rank-and-file leaders in the bargaining process. It is also clear from our experience that Tenet management believes there to be a clear distinction between the leadership/staff of the union and our members. Our ability to leaflet, wear stickers, march on the boss, and conduct an informational picket are severely constrained. The first contracts, though respectable, do not generally match the standards that we have been able to win in the remainder of the industry, with one notable exception. The exceptionally strong successorship language protected the Union when Tenet divested 18 of its California's hospitals. Since then it has become the standard that we have fought to include in other collective bargaining agreements.

The coordinated campaign in Tenet for this year's contract renewals provides our best opportunity to take advantage of our foothold in the company. While the Board of Inquiry process remains the method for final resolution of the contract, we have already begun organizing workers as part of the contract fight.

Just as the Kaiser contract motivates Kaiser workers to help organize their employer's competitors and help employees of other health systems of improve their standards, the Tenet agreement actually calls for an analysis of area standards if the third party becomes involved in settling disputes through the Board of Inquiry.

Finally, the situation at Tenet is comparable with that at CHW to the extent that, like CHW, several Tenet hospitals are strong candidates to participate in the National Labor-Management Project under development in conjunction with the Health care Division. Given Tenet's increasingly tenuous financial position, there is a compelling need for it to work with us to increase patient satisfaction. Ultimately, the company's survival may depend on it.

3.4 Strategic Alliance With Weak Workplace Power: Compass, Sodexo and the Nursing Home Alliance

While the Tenet agreement provides a foothold for building a true workplace organization in Tenet facilities, as far as we can tell, the agreements with Compass, Sodexo and the Nursing Home Alliance do not. This statement is qualified because despite representing Compass workers at two facilities, Enloe in Chico and Good Samaritan in LA, and despite the agreement applying to workers represented by the new national union in at least one of our facilities, Shasta Regional Medical Center, we have never seen a copy of the agreement.

From what we can tell, the Compass and Sodexo agreements do not create a foothold for building a real union in California hospitals with these employers but instead ensure the opposite: that a real Union will never get built. The situation at Shasta Regional Medical Center is most relevant here. While several hundred workers there are represented by our Union, along with nearly 800 workers at CHW's Mercy Medical in Redding represented by the same staff person, the 40

Compass workers at Shasta Regional are represented by the national Unite-HERE/SEIU subcontracted worker union based in New York. We don't believe there is another unit represented by this local within 200 miles. Furthermore, beside a very modest wage increase, the Compass contract appears to be little more than a grievance procedure with a just cause provision. So while Shasta Regional Medical Center workers represented by our Union are paid competitive wages, have fully employer paid health insurance, decent contract language and are part of a large, strong, locally based organization that represents more than 1,000 health care workers in the same city, the Compass workers represented by a local of the same international union have virtually no chance to meet those standards in their lifetime. The raise provided for by the contract appears to be just enough to pay union dues. How the facility will be represented and how the basics of steward training and contract administration will take place are prime considerations. Just how much energy will a nationally-based local union put in to organizing 40 subcontracted dietary and housekeeping workers in a location 2 ½ hours away from the nearest major airport? The concern that we have is the consequences of this situation in the exact same facility where we are trying to build a strong, vibrant workplace organization led by workers to defend workers' interests.

The strengths and limitations of the Nursing Home Alliance are discussed more fully in Section 2.5 above. But in terms of building worksite strength or creating a union presence in facilities, the alliance has severely stifled such activity, particularly in those facilities covered by the "template" agreement. For example, the grievance procedure applies only in cases of discharge, with quite extensive management rights fully intact. In both cases, incorporating workers covered by these agreements into a broader workers' movement is severely constrained by the structure of the collective bargaining relationship.

3.5 Adversarial Relationship: Sutter Health

The last type of employer relations is exemplified by our Sutter facilities, where we have been in a hot war with the corporation since 1996. Despite this ongoing war, the day-to-day labor relations in Sutter hospitals are generally constructive, though decidedly less so than at CHW or Kaiser facilities. Simply put, because of our industry strength we have been able to win industry-standard contracts at Sutter hospitals that are comparable or, in some cases, exceed their competitors. Remarkably, we arbitrate less than ten times per year total in Sutter facilities. Wages and benefits at Sutter hospitals, at least in the Bay Area, are the top of the market. Obviously there is no constructive engagement in legislative or political arenas; in fact, the legislative and political arenas have been the sites of intensely pitched battles.

From a union building standpoint, we have been able to recruit some of our most dedicated, truest leaders in our Sutter facilities. While the levels of intensity tend to wax and wane, based on the recurrence of contract fights, we have had an ability to resolve workplace issues even here. One precipitate of the on-going Sutter battle is its residual effects on those employers with whom we have a more constructive relationship, particularly CHW and Kaiser. The Sutter fight serves as a constant reminder to other employers of the flip side of a constructive relationship.

Part 4: Politics and the Power of a Unified Health Care Local

Our mission as a union is to improve the lives of the health care workers that we represent, as well as workers generally, through collective bargaining and other forms of struggle in political and social arenas. The improvements we achieve are greater and come more quickly when collective bargaining, organizing and politics function in mutually reinforcing ways.

Effective bargaining not only improves the lives of members immediately, but demonstrates to non-union workers the benefits of unionization. It also focuses the work of the members on the need for political strength and constantly provides a focus for political allies regarding the real, day-to-day struggles our members face.

Aggressive organizing—that is, increasing power—makes it possible to be more successful in bargaining and politics, incorporates more workers into the labor movement, teaches workers the importance of struggle, and maintains and expands workers’ power in a changing economy.

Strategic political action reinforces bargaining and organizing by building public and policy support for both. The union’s political action program also provides an arena and a means to address the broader issues facing workers that lie beyond the scope of collective bargaining, for example: the expansion of health care access, affordable housing, air quality (particularly in Fresno and the Central Valley), immigration rights, and other quality of life and civil rights issues.

Dedicating our political program first and foremost to supporting our organizing and bargaining efforts has yielded far greater response from our political allies than we might have hoped. The most salient example is U.S. House Democratic Leader Nancy Pelosi’s central role in helping to settle the CPMC strike. Over the years, we have had a constructive, but not particularly deep, relationship with Congresswoman Pelosi. In the past, she had played a behind-the-scenes role in other contract negotiations, making key phone calls, and had endorsed our organizing campaigns as one might expect from a progressive Democratic public official in San Francisco.

Yet, that does not explain the direct, personal role she played in the CPMC fight. It was 800 workers on strike for 60 days to win the right to organize, backed up by a year of work to educate her office on the issues at stake and to demonstrate the united support of lesser political and community leaders for our cause, that earned her committed support. Her willingness to play a direct, face-to-face role in the dispute was triggered, ultimately, by her reaction to picketers who were punched and beaten by the para-military Steele Foundation that Sutter had hired to provide security.

In short, engagement with the political process when workers are in a fight provides a political perspective to the workers and a worker perspective to the politicians. And it negates the employer defense that we see so often that a particular fight especially around organizing is one that is part of a “union agenda” rather than an issue for the workers.

Workers on strike have the potential to create an immediate sense of urgency among public officials and community allies. But that result, generally, is only possible when the relational foundations have been built before hand.

Our representation of long-term care workers, and especially homecare workers, has been instrumental in qualitatively improving our relationship with public officials at the state level, and even more significantly at the county and municipal level. Because so much of the work representing homecare workers is strictly political, it has required that we engage much more fully in city and county politics than we did before organizing the majority of our homecare members in the mid-1990s.

We attribute our strong political support at CPMC — with the full board of eleven supervisors in San Francisco publicly opposing CPMC’s efforts to rebuild its \$1 billion hospital — in large part to more than a decade of work fighting to win among the best homecare workers’ contracts in the country. Similarly, the Contra Costa County Board of Supervisors, with which we have built a successful relationship in representing that county’s homecare workers, has openly challenged the pre-eminent hospital system in that county – the John Muir health system that runs Mt. Diablo hospital in Concord – to settle an industry-standard contract with our union. Our potential to win supervisorial support for organizing private sector hospitals in Fresno will be greatly enhanced by winning a board majority who will consistently support our efforts to raise wages and benefits for the 10,000 Fresno homecare workers we represent. In short, support from public officials for

homecare workers in counties where we represent them has been dependably translatable to support for the Union's agenda outside the homecare sector.

The unification of health care workers in a single union has worked to the advantage of private sector hospital workers, but it has produced advantages to long-term care workers and public hospital workers as well. Our union has been at the forefront of protecting the public health system in Alameda County and the City and County of San Francisco, most notably spearheading a ballot initiative to guarantee the rebuilding of the world's largest nursing home, Laguna Honda, and as we speak, leading the fight to rebuild San Francisco General. Similar campaigns were replicated on a smaller scale in both Contra Costa and Alameda Counties to protect the funding streams for two smaller district hospitals, ensuring their survival. By marshalling the full resources of our Union, we have harnessed the collective power of all sectors of our Union to their mutual benefit.

4.1 The Advantage of Being a Unified Health care Workers Union: The Statewide Perspective

Our political work in support of homecare workers has also had a major positive impact at a statewide level. For more than a decade, we have worked in partnership with the SEIU State Council and, more recently, the California Homecare Council in statewide budget fights to establish, enhance and, more recently, preserve homecare funding. The statewide effort around homecare funding has been paralleled by full-scale reform of the state's nursing home reimbursement system. In both cases, these statewide efforts have involved thousands of our union's members in grassroots and State Capitol lobbying efforts and firmly established our Local as a major force in California politics, helping us to move our collective bargaining and organizing agenda in acute-care hospitals as well. While our work on acute care sector issues such as nurse staffing ratios and safe needle legislation has generated its own political constituency, our track record as a unified health care workers local capable of representing workers and advocating issues across all sectors of the health care industry has created political power for our organization as a whole that is much greater than the power of our individual parts.

4.2 The Role of the California State Council

Just as we believe that being a unified health care workers union strengthens our hand in politics, we also believe that our State Council must play an increasingly strong role to ensure that SEIU Locals speak with a unified voice in Sacramento. By prioritizing and coordinating our legislative agenda, spearheading statewide electoral activities, and lobbying as the voice of SEIU at the State Capitol, the State Council amasses our statewide capacity to maximize our political power. In the past six months, under our leadership and with the support of other locals, the State Council has made significant progress in orienting its work around SEIU's industry priorities and establishing enhanced standards of accountability. The State Council's strong commitment to health care reform is manifest in its work, already in motion, to prepare a universal access ballot initiative for the November 2008 general election. This work will begin in earnest not only through policy development, opinion research, and grassroots coalition building, but through the role of the State Council and its constituent Locals as the primary force in electing a pro-worker governor in California in 2006.

4.3 Building a Progressive Majority in California

Undertaking initiatives like health care for all in 2008 and creating a durable, statewide progressive majority are a fundamental part of our mission over the next several years. The establishment of United Health care Workers West as a statewide union has made our goal of building a progressive majority in California much more attainable. Over the past decade, our Union has been an integral part of every major statewide health care reform initiative. Proposition 186 (single payor) and Proposition 214 (HMO reform) were both written in our union's Oakland office. We were at the forefront of the fight to pass 2004's Proposition 72 and won the support of our major health care provider allies, Kaiser Permanente and Catholic Health care West, for the initiative, which lost by a razor thin 160,000 votes out of 11.5 million cast.

To continue to grow as a health care workers union and to serve more than the narrow material interests of our members, we believe it imperative to use our power not just to advance our goals in collective bargaining and organizing, but to create a just and humane society in California at large. In so doing, we are committing to make our union into a vehicle for broader social change.

Part 5:

Worker Engagement, System Campaigns and Market Campaigns

Perhaps the strongest lesson we have learned from both the Catholic Healthcare West campaign and our ongoing war with Sutter is the importance of basing our fight on mobilization of workers, whether they are workers fighting for a contract or workers fighting for the first time to win a union. Without workers at the forefront engaged in struggle, we continually lack credibility with workers, elected leaders and potential community supporters, and the employer.

With that lesson learned, we are approaching our major health system organizing in the following way in the following market/system campaigns:

5.1 Orange County

Currently there are more than 15,000 unorganized workers at hospitals in Orange County, but there are also 3,000 workers at Kaiser and Tenet/formerly Tenet facilities in Orange County who are already represented by our Union. Our approach is to create a hospital workers' movement in Orange County that unifies Tenet, Kaiser and unorganized workers. Because Kaiser and Tenet workers have a material self-interest in raising area standards as a benchmark for raising their own, we believe there is an appropriate nexus to build a collective form of organization. Because of Tenet bargaining this year, we expect the level of interest among Tenet workers to be particularly high. By going county-wide, rather than initially focusing on a single system, we believe we will build a truly organic workers' movement with the flexibility necessary to move as we create specific opportunities with individual Orange County hospitals or systems.

But our model for organizing health care workers is not limited to just hospital workers.

In concert with SEIU Local 434B, we want to create a broader health care workers movement that links organizing hospital workers with organizing the thousands of unorganized nursing home workers in Orange County. In fact, our effort in Orange County will not be limited to just health care. In addition to the coordination with 434B, the Change to Win Coalition has prioritized the county as one of its first areas of focus as UNITE-HERE in hotels and restaurants and SEIU Local 1877 in property services join forces with us in a multi-union effort.

5.2 Sisters St. Joseph of Orange:

The Sisters of St. Joseph of Orange is a combination market campaign and system campaign. Four SSJO hospitals are in Orange County and will be incorporated into the broader Orange County campaign. In addition, there are four SSJO hospitals in Northern California in the North Bay. At the system's flagship hospital in the North, Santa Rosa Memorial Hospital, there is a vibrant, intense worker committee that has driven the fight for a contract. A strong community campaign, built off the fight for the union and first contract at the Ensign nursing home in Santa Rosa, has evolved into a broad, well respected workers' rights voice in the community. At two of the other hospitals in the North Bay, the CNA already represents the registered nurses. Finally, and similar to Orange County, there is already in the North Bay a substantial base of workers already represented by our Union. There are 900 Kaiser members at Kaiser Santa Rosa. Sutter Santa Rosa with 900 workers (the former public hospital represented by SEIU Local 707 that we now administer through a service agreement) and Sutter Lakeside with 150 workers in nearby Lakeport are part of the larger Sutter fight. We also represent several nursing homes, a couple of clinics, and 2,200 homecare workers in Sonoma County.

5.3 San Diego

There are approximately 20,000 unorganized workers at 17 hospitals in San Diego. The majority work at two regional hospital systems: Sharp and Scripps. Again, our theory in San Diego is similar to that outlined above in Orange County and SSJO. Like Orange County, San Diego also is ripe for a united campaign with 434B to organize the county's unorganized nursing home workers. We recently overwhelmingly won a tough decert fight at San Diego Children's Hospital, which was organized by SEIU Local 2028, then transitioned to UHW. In the wake of Local 2028's stalled campaign to get card check recognition at Tri-Cities - one of the county's four district hospitals - we hope to use successful attempts to organize the other San Diego district hospitals, together with a contract victory at Children's, to establish a base for more intense organizing in the county.

5.4 Fresno

The dominant, non-union provider in Fresno is the Community Hospital System in Fresno that consists of more than 7,000 workers at three hospitals including what used to be the public sector county hospital. Fresno has been the county where we have fought the hardest to win a contract for 9,000 homecare workers and where we have invested enormous time and effort in building a community campaign to support them. Many of those community supporters have ties and influence with the leadership of the Community Hospital System and have family members who work in the CHS hospitals. Fresno is also the site of our strongest union worksite at the Kaiser Fresno facility discussed above. Lastly, we represent a handful of nursing homes in the Fresno area and intend here as well to unify hospital worker and nursing home worker organizing into a coordinated campaign. Once again, similar to the general model outlined above in Orange County and SSJO, our plan is to create an integrated workers' movement in Fresno, uniting organized Kaiser, nursing home and homecare workers with unorganized Fresno health care workers.

Finally, Fresno is also a place where our goal of building a progressive majority in California dovetails with using our political power to support contract and organizing campaigns. We have been fighting to build a pro-worker majority on the County Board of Supervisors and are working to mount a campaign for a third (and majority vote) in the next election round. We have also been instrumental in helping to elect and then retain moderate Democratic state legislators in close victories against strong right-wing opponents.

5.5 Providence

In coordination with SEIU's Healthcare Division, and Locals 49 and 1199NW, we have been part of the overall system-wide fight with the Providence Health system. There are an additional three unorganized Providence hospitals in Southern California. In a short period of time, we have been able to use political connections with L.A. County Council President Alex Padilla and Mayor Antonio Villaraigosa to delay Providence's hospital construction project at Mission Hills. The Providence campaign also provides a tremendous opportunity to rebuild what has been a weak facility, St. Joseph's of Burbank, through the development of a comprehensive contract campaign in support of the larger organizing campaign when that contract is up for renewal in the spring of 2007. The fight for standards at St. Joseph's, a large, strategically targeted hospital, will reinforce our goal of incorporating key Southern California hospitals into the massive contract campaign cycle described in the first part of this paper.

5.6 Conclusion

If successful, the campaigns outlined here collectively have the potential to organize over 80,000 health care workers into our Union. In the process, major markets like Orange, Fresno and San Diego counties that to date have been predominantly non-union will become majority union. Taking these markets union will obviously produce a profound improvement in the lives of hospital workers in these counties. But our success will transcend simply raising wages and benefits and improving working conditions for hospital workers there. It is no coincidence that these three counties are among the most conservative major population concentrations in the entire state. We believe successful campaigns in these markets will move these counties in a progressive direction politically.

Just as importantly, by focusing on building fully-rounded, cohesive campaign teams, we expect to be able to move immediately into multiple system/mini-market campaigns to complete the unionization of the hospital industry in California. By understanding that goal going in, we hope to avoid the de-stabilization that occurred in Southern California after the first wave of Tenet elections in 2004, when many of the most talented, experienced, and savvy leaders who led and contributed to the cohesive team that helped to organize CHW and Tenet in Southern California were quickly re-deployed out of state, thereby disrupting our ability to drive campaigns throughout the rest of the region.

Part 6: UHW's Role as a Lead Local

We believe that our success as a union derives from several different factors: the power of being a unified, statewide health care workers local; our willingness to fight to raise standards for health care workers; an experienced, unified and diverse leadership that is representative of and accountable to our membership; the resources of a large local union; and a vision for where we want our Union to be in 2010 and beyond.

6.1 The Institute for Change

In 2002, our local was proud to be selected as one of the original unions to participate in the New Strength Unity Institute, since renamed the SEIU Institute for Change. Our participation had several positive effects on our Union beginning with further consolidating and deepening the relationship of our leadership team. Two additional benefits stand out. First, creating a medium-range vision of where we wanted our Union to be eight to ten years in the future was extraordinarily valuable in helping us to look beyond the immediate campaigns and crises we faced in order to prepare for our next stage of development. Secondly, the Institute for Change made painfully obvious that our aspirations were unlikely to be successful if we did not consciously develop staff and rank-and-file leadership by nurturing talent, raising expectations, and more deeply empowering staff and members in determining the future of our Union.

6.2 Our Vision for 2010

Through hundreds of meetings in our local, including our Executive Board, division steward councils, facility steward councils, staff meetings and more culminating in our 2004 Leadership Conference, we adopted an ambitious vision:

- uniting all California health care workers into our Union or acting like one union by 2010
- improving the lives of California health care workers
- winning equal rights and status of all workers
- building a progressive majority in California
- achieving universal access to the quality health care
- revitalizing the labor movement

Since we adopted our vision just over two years ago, we have since recognized that it was not ambitious enough. Specifically, we need to look beyond California. We reflected that recognition in the name of our new local—SEIU United Health care Workers West, rather than UHW-California. Through relationships with employers like Kaiser and Catholic Health care West, we have already had an impact on expanding our representational reach and raising standards in Colorado, Nevada and Oregon. The potential for this type of engagement is most developed in Kaiser where we are now involved with Kaiser in decision-making about future hospital and system expansion, both within and outside California.

6.3 Education and Leadership Development

We quickly understood that if we were going to be successful in achieving this vision, we needed to develop more leaders, both at staff and rank-and-file levels, who shared our vision and who had the ambition and drive to accept the responsibility to carry this out. Since 2000, but even more so in the last year, we have redefined and strengthened our education department. From a staff development perspective, there is a greater emphasis on training: union-wide training, division training, and individual training to equip our staff with the tools necessary to lead workers. For the first time this year, we will conduct a four-day new staff retreat to orient new staff to the union. We will also conduct our first comprehensive bargaining training. Working with staff from the Health care Division and the Talent to Win program and the Institute for Change, we are also undergoing a thorough staff assessment process to match staff capabilities and talent with various campaigns and programmatic opportunities.

Over the past several years, we have also developed a comprehensive basic steward training and an advanced steward training program. Throughout the year, in steward council meetings, division meetings and individual training sessions, stewards now have multiple opportunities to improve their leadership skills. Our core program is our basic steward train-the-trainer program in which staff and rank-and-file leaders are trained to conduct our two-day basic steward training program that is then taught hundreds of times throughout the year.

Related to our goal of internal leader development, we recognize as a lead local that we have the responsibility to use that

position to provide leadership development opportunities for SEIU leaders from across the country. This generally has taken place two ways. Many staff leaders from UHW have played leadership roles in SEIU locals outside of UHW. UHW led the multi-local bargaining with Kaiser and CHW. UHW leaders were instrumental in helping to lead contract/organizing campaigns in Las Vegas, Oregon, Florida, and Minnesota. Our Local has also been a place where leaders from other locals can gain experience in situations that they may not have experienced in other locals. The best, most recent, example, is the Sutter strike where a number of energetic, enthusiastic new staff leaders from across the country played a vital role in helping to win the strike.

The most exciting development in this area has been the establishment of a multi-million dollar training and upgrade fund, first with Catholic Healthcare West and Kaiser and today expanded to include most major unionized hospitals in California. SEIU Locals 49, 105, 121, and 1107 are already part of the fund, and serious discussions are under way with Locals 434B and 660 to either join or more closely coordinate work with the fund. In our view, over time the training and upgrade fund will become the vehicle for health care workers to improve their skills, upgrade their qualifications and/or enter the health care work force. For employers, we see the fund as evolving into the primary place to which they turn to meet staffing needs in an ever-changing industry.

6.4 The Union as a Social Center

We are leading a health care workers movement in the West. There are multiple components to this movement, many of which are touched upon in previous portions of this document. To reiterate, in closing, the major components are these:

1. We need to raise standards for health care workers.
2. In order to raise standards, we have to organize more workers to build workers' power, but we also need to exercise our power by fighting to raise those standards.
3. We must create a culture of struggle in which workers learn to fight: for the union, for higher wages and benefits; for a real voice at the workplace, for broader legislative advances.
4. We need to transform the union into more than simply a vehicle for organizing workers and negotiating contracts. That is the value of our Shirley Ware Education Center and our Training & Upgrading Fund. It is also the value of focusing on issues that affect our members outside the workplace: affordable housing, immigration rights, public education, air quality and more.

As a unified, statewide health care workers' union, we are creating a movement of health care workers in which the union becomes once again a major institution in our members' lives.