

Seth Sandronsky wrote an excellent article about the negative effects that the Senate's Comprehensive Immigration Bill (S.2611) will have on domestic nurses. He has a firm grasp on the fact that immigration is being used as a weapon to flood labor markets and to bust unions.

Sandronsky made one factual error:

Contrast the Senate's immigration provision for the labor shortage of U.S. nurses and a national labor policy for medical doctors. There is a government restriction on the number of foreign physicians who may practice medicine in the U.S.

His assumption that doctors would be better off than nurses if S2611 passed isn't correct. S2611 has an exemption from the employment based green card cap for a wide variety of occupations -- including medical doctors in "SEC. 505. SHORTAGE OCCUPATIONS". The bill gives exemptions to aliens who have an advanced degree in science, technology, engineering, math, college professors and researchers, and any other category that the DHS decides to waive. The green card, or EB visa, is unlimited for foreign physicians who agree to work in a location designated by the Department of Health and Human Services as having a shortage of health care professionals (in other words, in lousy areas that most doctors don't want to practice in). This exemption will last until September 30, 2017 at which time most white collar professions in the USA will be on the endangered species list.

***** READ THE PREVIOUS PARAGRAPH AGAIN VERY CAREFULLY

... because you might have missed the fact that all shortage occupations will be subject to unlimited green card visas. Decisions about what job categories have shortages, and therefore which are exempted, would be totally at the whims of the DHS. If you are an engineer, scientist, or programmer you will be thrown to the wolves just like doctors and nurses!

Sandronsky overlooked another piece of legislation that is just as devastating to doctors and nurses. Section 201 of the Skil Bill (H.R. 5744 and S. 2691) contains an identical visa exemption as S2611. The Skil bill has a much higher probability of passing through Congress because it's a standalone bill that continues to be off the radar screen of immigration and labor activists.

Sandronsky also failed to mention the threat that H-1B poses for doctors

and nurses. H-1B visas can be used for almost anyone in the medical industry, and of course the numbers of H-1Bs will be dramatically increased if either S2611 or the Skil bill is passed.

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A Joint Attack by the Senate and the NLRB

The War on Nurses and Other Workers

By SETH SANDRONSKY

These are trying times for U.S. labor unions. Their strength is on the wane. There are many reasons why. One reason is a fierce attack by employers and the federal government. Some of the attacks are harder to see than others.

A provision in the recently passed Senate immigration reform bill expands the number of foreign nurses who may work in the U.S. Lifting this cap on immigration is the idea of Sen. Sam Brownback, a Kansas Republican, and backed by the American Hospital Association. The AHA represents hospitals, health care networks and systems. Since the 1990 federal election cycle, the AHA has spent just under \$13 million, split about evenly between Democrats and Republicans, to lobby candidates, according to the Center for Responsive Politics.

Immigration is an economic issue. It crosses national borders. Government's role is crucial in this movement of working people. Case in point is the opening of the U.S. job market to some foreign workers. Contrast the Senate's immigration provision for the labor shortage of U.S. nurses and a national labor policy for medical doctors. There is a government restriction on the number of foreign physicians who may practice medicine in the U.S. Thus domestic doctors are the most highly paid in the industrialized world. Why? U.S. doctors are insulated from foreign job competition.

Such insulation from foreign competition limits the supply of doctors practicing medicine in the U.S. A limited supply of doctors practicing medicine stateside increases the demand for their labor services. This policy boosts doctors' annual salaries. Their high pay drives up the over-all price of health care throughout the country's economy.

No other nation pays more for its health care than the U.S. In 2003, the U.S. spent 15 percent of its gross domestic product on health care versus five percent in 1960, according to the Organization for Economic Co-operation and Development. The U.S. lacks universal coverage. Canada spent 9.9 percent of its GDP on health care in 2003 compared with 5.4 percent in 1960. All Canadians have health-care coverage.

In the meantime, the weakening of U.S. blue-collar workers' protection from foreign competition has driven down their real wages, or what their pay can actually purchase in the marketplace. The Senate's provision in its immigration reform bill will drop the wages and benefits of native-born nurses both inside and outside of labor unions. This is the desired outcome for the AHA, U.S. Chamber of Commerce and the National Right to Work Foundation, the lowering of their constituencies' costs for labor services. In this way, lower wages help to boost profits for employers.

Nursing homes operators and home health-care employers are also seeking more foreign workers. These workers earn very low wages. The American Health Care Association, which represents for-profit nursing homes, and the National Association for Home Care both joined an industry coalition to lobby Congress for a new visa that they hoped would annually admit 400,000 low-skilled workers -- the grist of the home-care field -- which would be equal to the number that now arrive illegally" (Wall Street Journal, July 26, 2006). It is unclear what is low-skilled about caring for people living in their homes. Nevertheless, the basic point that immigration is a labor issue remains.

On another labor front, the Wall Street Journal reported on July 23 that a summer ruling by the U.S. National Labor Relations Board could change the employment status of some of the nation's nurses and other wage earners by re-classifying them as supervisors who use "independent judgment." Significantly, supervisors cannot be in unions, U.S. labor law says.

The National Labor Relations Act, the nation's primary law determining the rights of employees to join unions and bargain collectively, excludes "supervisors" from the definition of "employee", according to an issue brief from the Economic Policy Institute (EPI). The Act defines a "supervisor" as "any individual having authority, in the interest of the employer, to hire, transfer, suspend, lay off, recall, promote, discharge, assign, reward, or discipline other employees, or responsibly to direct them, or to adjust their grievances, or effectively to recommend such action, if in

connection with the foregoing the exercise of such authority is not of a merely routine or clerical nature, but requires the use of independent judgment."

President George W. Bush appointed each of the five current NLRB members. President Clinton appointed the previous members of the labor board. The United States Supreme Court has twice rejected prior Board rulings for minimizing the importance of independent judgment in the assignment or direction of employees by nursing personnel, the NLRB stated in a press release. In those cases, the Board found that nurses who direct other employees in their patient care duties are not statutory supervisors."

In 2001 in a 5-4 ruling, the U.S. Supreme Court found the Clinton NLRB's interpretation of "independent judgment" to be wrong. The Court ruled that registered nurses on the payroll of Kentucky River Community Care used independent judgment through oversight (such as scheduling) of co-workers' labor. Therefore, the RNs should have the occupational status of supervisors under U.S. labor law, according to the Court.

Now at stake in the Bush NLRB decision on the Kentucky River cases, pending since 2002, is the supervisory status of charge nurses employed by health-care facilities in Michigan and Minnesota and manufacturing workers ("leadmen" and "load supervisors") in Mississippi. In terms of the corporate healthcare sector, consider a brief filed by the AHA to the Bush NLRB.

The charge nurse's role presumes an education and experience that equip him or her to assume a management function. If charge nurses are not perceived as supervisors with managerial prerogatives, the quality of patient care will suffer, hospitals will continue to experience staff shortages and the already significant financial burdens on hospitals will increase. Charge nurses' loyalties will be strained and their already challenging job of ensuring quality care will only become more difficult.

A ruling by the NLRB, the federal agency that certifies union workplace elections, is expected soon. Up to eight million employees inside and outside of labor unions could be affected, according to the EPI. These women and men toil in dozens of occupations, from construction to financial services and health care.

Clearly, an NLRB ruling reclassifying nurses and millions of wage earners as supervisors would cut the potential number of unionized employees in the U.S. Plus, overtime wage rates would likely drop or disappear for the newly created category of salaried supervisors. They would see their workloads increase without a rise in pay. Moreover, employees now in unions could lose their contract protections. Welcome to President Bush's ownership society.

What is to be done in the face of the Bush NLRB and Republican controlled Congress? For one answer we turn to the 65,000-member California Nurses Association. Registered nurses are the mainstays of the CNA, which also represents nurses through the National Nurses Organizing Committee across the U.S. Crucially, the CNA has been a strong backer of universal health for the U.S. populace, and endorsed anti-war and consumer activist Ralph Nader as a presidential candidate in 2000.

The CNA, which was an independent union that decided, in fall 2005, to consider joining the AFL-CIO, has gone beyond getting more bread and butter for its rank and file to advocating for the general public. In 2004, California Governor Arnold Schwarzenegger (transforming himself into a liberal Republican now) threw down the gauntlet to the CNA concerning hospital staffing requirements. He sought to keep the ratio of one nurse to six patients. A state law signed by the previous governor, Democrat Gray Davis, required the ratio to drop to 1-5. As an advocate for improved patient care, the CNA opposed Schwarzenegger's move. Everywhere he went in public, the nurses union was there to meet him with protest rallies. This political stance surely has its roots in the largely untold and under-appreciated history of female nurses standing up to male doctors. That book waits to be written.

Schwarzenegger's hospital proposal preceded the special election he called for November 8, 2005. Momentum created by the nurses union helped to defeat all four of the governor's ballot measures. His measures would have changed laws on public teacher tenure, labor union dues, legislative district borders and the state budget. A kind of united front emerged to battle the governor. CNA's popularity rose. His dropped. Working people united to take down a politician and his paymasters. There is a lesson here for California and the nation. The lesson goes far beyond voting for or against a ballot measure.

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