Neoliberalism, Globalization, Health, and Health Care

DOUBLE JEOPARDY: THE IMPACT OF NEOLIBERALISM ON CARE WORKERS IN THE UNITED STATES AND SOUTH AFRICA

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Many researchers have explored how neoliberal restructuring of the workplace has reduced the standard of living and increased workplace stress among private sector employees. However, few have focused on how neoliberal restructuring of public policy has had similar effects on the public sector workforce. Using original case study research, the authors examine how two iconic pieces of neoliberal policy—the 1996 welfare reform bill in the United States and the GEAR macroeconomic policy in South Africa—affected public/nonprofit human service workers in New York City, United States, and public sector nurses in KwaZulu-Natal, South Africa. The authors argue that in both situations, despite national differences, these policies created a "double jeopardy," in which patients/clients and care workers are adversely affected by neoliberal public policy. This "double jeopardy" creates significant hardship, but also the opportunity for new social movements.

Since the 1970s, neoliberal health and social welfare policies around the world have shifted resources from the public to the private sector, reduced benefits to recipients, and affected the lives of clients and workers alike. While many researchers have studied the negative impact of these policies on the well-being of the clients of health and human service agencies, and of workers in the private sector, less is known about the adverse effect of neoliberal disinvestment on the well-being of health and human service care workers.

This article draws on case studies to examine the impact of neoliberalism on care workers in New York City (NYC), United States, and KwaZulu-Natal (KZN) Province, South Africa. Despite national differences, both governments have actively pursued neoliberal disinvestment in health and social services, which

International Journal of Health Services, Volume 40, Number 1, Pages 97–117, 2010

doi: 10.2190/HS.40.1.f
http://baywood.com

has undermined the well-being of clients/patients and care workers. Neoliberal policies have deprived the former of basic resources needed to survive and the latter of the time and resources needed to serve client/patients well. At the same time, these intertwined impacts, which we term "double jeopardy," create the conditions for a potentially important alliance for resistance to neoliberalism.

THE SHIFT TO NEOLIBERALISM IN THE UNITED STATES AND SOUTH AFRICA

Despite different trajectories, both the United States and South Africa adopted the neoliberal, laissez-faire paradigm to address stalled economic growth. In the late 1970s and early 1980s, changes in the domestic and global economies led to economic problems for business and the state and prompted an attack on the welfare state. For South Africa, by the mid-1990s, the prevailing logic among world powers following the fall of apartheid was for the country to replace national development plans—including investments in the public sector—with export-focused global economic development, deficit reduction, and spending cuts (1). The resulting austerity increased inequality in the United States and curtailed the democratic promise of rule without apartheid in South Africa.

United States

Implementation of the neoliberal agenda in the United States represented an effort to deal with the country's second major economic crisis in the 20th century. The first major economic crisis—the collapse of the economy in the 1930s—led to the rise of the welfare state. Pressed by the combination of militant social movements and structural changes in the economy, some in the more liberal wing of the national elite blamed the period's economic problems on the failures of the market and saw greater government spending as the way out. Overriding those in the business class who favored private sector solutions over an expanded role for the state, the liberal wing successfully called on the government to offer a New Deal that would restore profits by fostering economic growth and muting the social unrest sparked by the Great Depression. From 1945 to 1975—often called the "golden era" of capitalism—the U.S. welfare state grew in response to population growth, the increased need for assistance, and the victories of increasingly militant trade union, civil rights, women's liberation, and other movements (2–4).

From 1935 to 1975, the expanded welfare state helped save capitalism from itself by carrying out a complex set of social, economic, and political functions that mediated poverty, enhanced profits, and quieted political protest (2). However, in the mid-1970s, structural shifts in the global economy challenged the power of the United States (2–16), creating economic problems that led leaders in business and government to blame their new financial woes on the public

programs that had grown since the Depression, the gains of social movements, and "personal irresponsibility."

The response to the economic crisis in the 1970s, including the export of production, reduced capital's reliance on U.S. workers (17, 18). The globalization of production, in turn, left business increasingly unwilling to support the welfare state programs that during the past 40 years had enhanced profits by increasing consumption, maintaining the current and future workforce, and appeasing social movements. Business and government also blamed the welfare state for the nation's enlarged deficit, rising interest rates, and other barriers to investment and economic growth (8–10, 19). Finally, the postwar gains of social movements—especially higher wages, more generous welfare benefits, and stronger movements—had raised both the standard of living and the political costs of social welfare spending as a means to maintain the social peace (13).

South Africa

Like the United States, in the 1980s, while still under apartheid rule, South Africa also faced a crisis of profitability, the nature of which was, and continues to be, intensely debated (20–28). By then, at least some of the South African business sector wanted both to dismantle the institutional arrangements of apartheid and to promote South Africa's participation in the global economy. They regarded economic liberalization as an important accompaniment to political liberalization, and hence relaxed exchange controls, tariff cuts, higher interest rates, commercialization, and privatization, and many forms of deregulation ensued simultaneously under the pressure of the Urban Foundation and similar business lobbies (29).

A more profound crisis emerged in South Africa when the expectations forged during the anti-colonial and anti-apartheid struggles failed to be met. Global recession, the 1989 collapse of state socialism, and a decade of structural adjustment policies had intensified poverty and disease on the African continent. International support for state socialism dried up, and Margaret Thatcher famously proclaimed that "there is no alternative" to the free-market approach to economic growth and development. The focus among international elites on financial liberalization, austere monetary policy, and cuts in social spending undercut conditions for social development. Pressed by these forces, the African National Congress (ANC) adopted neoliberal policies that undermined social goals and compromised the democratic agenda that had propelled the party to victory in 1994. For example, to appease the business elite and to signal its future intentions, in 1994 the ANC agreed to pay back US$25 billion of apartheid-era debt with a loan from the International Monetary Fund (1). Among other things, this step drained resources away from national development, including spending on the public sector. In 1996, the ANC adopted the Growth, Employment and Redistribution program (GEAR), labeled by some as "homegrown structural

adjustment."[1] The GEAR program focused on rapid trade liberalization and fiscal deficit reduction, and replaced national development goals with export-led growth and global market participation. With this, South Africa's comprehensive development program gave way more fully to the neoliberal agenda (31).

Neoliberal Strategy and Tactics

Neoliberalism sought to promote economic growth by an upward redistribution of income and wealth, a greater reliance on the "free market," and a downsizing of the state.[2] In both South Africa and the United States, neoliberalism called for lowering labor costs, reducing social spending, limiting the domestic role of the national government, and weakening the influence of social movements (2). The specific U.S. tactics included tax cuts, retrenchment of social programs, devolution (the shift of social welfare responsibility from the federal government to the states), privatization (the transfer of public responsibility to the private sector), and an attack on social movements best positioned to resist the austerity program. Similarly, in South Africa the government cut public spending, called for deficit reduction, lowered public sector wages, intensified privatization, and otherwise diverted monies from comprehensive national development (32, 33). Business and government promised the citizens of both countries that the benefits of this pro-market strategy would trickle down to the average person. But instead, neoliberalism reduced the effectiveness of health and human services, increased workplace stress, and undercut the well-being of both the health and human service workforce and the people and communities they served.

THE IMPACT OF NEOLIBERALISM ON HEALTH AND HUMAN SERVICE WORKERS IN NEW YORK CITY AND KWAZULU-NATAL

A good deal of research explores how neoliberal restructuring of the private sector workplace reduced the standard of living and job quality and increased workplace stress (34–37). However, less research has examined the health and well-being of health and human service workers as neoliberal public policy has, in effect, restructured their workplaces and left patients and clients to absorb the losses. The

[1] The plan was opposed by the South African Communist Party (SACP) and by the Congress of South African Trade Unions (COSATU), the largest federation of trade unions in the country—the two other members of the tripartite government structure. Instead of neoliberalism, they favored social policies to redress apartheid's legacy of inequality, including a universal social security system known as the Basic Income Grant (30).

[2] In addition to reduced social spending, downsizing of the state includes reducing impediments to a so-called free market by attacking regulations aimed at protecting labor, the environment, and regional/national interests, with the hope of "leveling the playing field" for multinational corporations.

following two case studies, of human service workers employed in nonprofit agencies in New York City and nurses employed in public sector hospitals in KwaZulu-Natal Province, describe how neoliberal restructuring has exacerbated long-standing conflicts built into the provision of health and social services and introduced new tensions.

In both countries, the application of neoliberal policies in the public and nonprofit sectors left agencies/hospitals with fewer and fewer resources to meet the deepening needs of their clients and patients. The policy changes placed health and human services "in jeopardy" and turned stress into a major occupational hazard for care workers (36, 38–47). Women and persons of color, the majority of clients/patients and many of the workers in health, education, and social services in both South Africa and the United States, bore the brunt of neoliberal policies (48).

Welfare Reform and the Nonprofits: Neoliberalism in New York City[3]

Although not the first or only initiative, welfare reform stands out as the icon of neoliberal social policy in the United States. The dismantling of the income-support program for single mothers—which disproportionately serves women of color—represents the earliest effort to eliminate an entitlement program, the strongest type of social welfare provision in the United States. In response to the collapse of the economy in the 1930s, the federal government had accepted responsibility for providing at least a bare-minimum safety net, and the resulting welfare state expanded steadily during the postwar years. By the 1960s, rising costs, growing demands, and the increased power of municipal unions led city and state governments to contract with local nonprofit agencies to provide social services. The resulting flawed but workable public-private system has served individuals and families ever since.

In the 1970s, the United States faced the second major economic crisis of the 20th century, as the forces of deindustrialization, globalization, and other structural changes led leaders in business and government to increase their profits by replacing high-paying manufacturing jobs with low-paying service jobs, sending private sector jobs abroad, and enacting tax and spending cuts. By the early 1980s, instead of using social welfare policy to ameliorate the resulting job loss, poverty, and other social problems, the newly elected Reagan administration pursued the neoliberal policy of disinvestment.

In the ensuing decades, mounting job loss, wage reductions, and increased health, housing, and food insecurity pushed large numbers of poor and working-poor households into poverty and despair (50, 51). The resulting family crises increased the demand for health and human services, but the loss of government

[3] Original data analyzed in this section were collected by Abramovitz (40, 41, 49).

support for human service agencies limited their capacity to respond to the growing needs. The economy improved during the booming 1990s, but in the early 2000s, tax cuts, continued hostility to government programs, reduced social spending, and slowed economic growth left low-income communities and social agencies without crucial resources.

After two decades of austerity, the 1996 federal welfare law advanced the neoliberal agenda by gutting Aid to Families with Dependent Children, a major U.S. entitlement program that served single mothers and their children. The loss of these and other benefits increased the financial vulnerability of clients, forced them to accept low-wage work, and further undercut the capacity of nonprofit agencies to meet client needs. The move toward privatization directed government funding to for-profit and faith-based organizations, leaving fewer public dollars for the nonprofit human service agencies expected to pick up the slack of welfare reform (52, 53). The changes fell especially hard on low-income women in New York City, as the Giuliani administration stressed deterrence and sanctions to create one of the more punitive versions of welfare reform in the nation (54).

The impact of welfare reform on human service workers was explored through in-depth interviews with senior staff at 107 NYC nonprofit agencies representing a wide range of service areas and located in all five boroughs of the city (40). These disparate agencies turned out to be surprisingly uniform in terms of the problems created by welfare reform. Although the job of human service workers has never been easy, it became much harder after 1996. Welfare reform simultaneously fueled economic crises and emotional distress among clients and undermined the working conditions that made it possible for human service workers to meet clients' needs. More than 90 percent of the agencies surveyed indicated that welfare reform affected how workers carried out their jobs (49). Having to run uphill in an attempt to fix the problems created by welfare reform significantly increased stress and burnout for many human service workers.

Increased Demand. As welfare reform denied more and more clients access to needed benefits, they turned to nonprofit agencies for help. The demand for help with workfare issues rose at 81 percent of the agencies in the study, for help with eligibility rules at 76 percent, and for help with Medicaid problems at 72 percent. Agencies also reported increased requests for help with food stamps, citizenship, and child care. Client requests for help with specific services also increased at many of the agencies. The demand for help with job training services increased at 77 percent of the agencies, for child care at 79 percent, for access to food pantries at 69 percent, and for access to housing at 68 percent. The need for assistance accessing Legal Aid, immigration advice, and English as a second language programs also mounted. Finally, following welfare reform, workers also had to spend more time helping clients understand the new welfare rules. Workers spent more time helping clients with workfare at 75 percent of the

agencies, case closings at 72 percent, job search at 66 percent, fair hearings at 66 percent, and sanctions at 60 percent.

The director of an HIV/AIDS program concluded that since welfare reform, "we deal [more] with the day to day aspects of negotiating the system." A social worker at a battered women's shelter explained: "We sometimes take the role of the system that is no longer there. We have become the safety net, which is not the way it is supposed to be."

Increased Work Intensity / Speed-up. In addition to increased demand, the intensity of work also mounted following welfare reform, as was evident in various routine agency operations. Eighty-six percent of the agencies reported increased documentation and paperwork, 76 percent reported more contacts with the welfare office, 70 percent engaged in more outreach, 49 percent experienced increased caseloads, and 44 percent had more staff overtime. "It's just gotten more difficult. That's the bottom line," said the program director at a program for immigrants.

The speed-up resulting from the increased use of performance-based contracts, numerical caps for client visits, shorter lengths of stay in programs, billable hours, and other neoliberal productivity measures compounded the growing work intensity. The director of a foster care agency explained: "These days you just have to produce more." According to a supervisor at a school mental health program: "We are doing more to meet the same goals." "We have to do [everything] quicker now," stated the unit supervisor at an employment program for substance abusers. The executive director of a domestic violence program declared: "Everything is on a clock!"

Demand Shift / Picking Up the Slack. Before welfare reform, workers could assume that government programs provided a minimal level of subsistence that buffered families against crises and freed workers to address other client needs. Following welfare reform, workers spent the majority of their time helping clients with welfare rules and penalties and managing crises that surfaced when welfare's harsh new requirements tipped the financial and emotional balance of many already vulnerable families. According to a social worker at a foster care prevention program, "We are spending more and more time just to make sure that they have their basic needs. So it is not counseling, it is not parenting, it is not all the other things you want to give them." The division director of a battered women's shelter declared that "welfare reform has forced us to deal with concrete issues at the expense of psychological and intra-psychic issues. The emotional issues get put aside because the concrete stuff is so overwhelming." Substance-abuse program workers reported that since welfare reform, job placement has trumped vocational rehabilitation, drug treatment, and supportive service.

Less Control on the Job. The welfare overhaul also deprived human service workers of a sense of control over their job. Workers from a wide range of agencies reported the decline of five basic conditions needed to carry out their regular responsibilities: (*a*) predictable presence of clients, (*b*) enough time to think and plan, (*c*) access to timely information, (*d*) adequate government resources, and (*e*) professional autonomy. The loss of autonomy ranked especially high. Speaking for many, a social worker at a program for ex-offenders stated: "Sometimes I feel that the welfare department is the one dictating and no matter what, I have to follow." Workers also suffered a lack of cooperation from the welfare department, whose case managers they described as more "inaccessible," "uninformed," and "rude" since welfare reform. Some human service workers attributed this behavior to job stress in the welfare office, but added that the lack of help left them unable to do their job.

More Ethical Dilemmas. The neoliberal welfare environment created many ethical issues for social workers. Welfare's new, harsher rules for clients forced workers to choose between following government rules and honoring professional commitments (55). Welfare reform exacerbated the long-standing tension between the professional commitment to protect client confidentiality and the welfare department's reporting requirements. If reported to the welfare agency, the receipt of a small amount of additional income, a positive urine test, or other infringements of the rules typically cost clients their government benefits. One program director noted: "We are stuck. We try to build trust so people [are willing] to tell us what's really going on. But then we are in a position to use that information against them." Professional ethics stress client self-determination, yet practitioners often had to push clients to enter a work program or a parenting class, whether or not it was in their best interest. A supervisor at a school-based mental health clinic stated that this "raised ethical issues because you are really talking about someone's autonomy as an adult, making choices in their lives." Staff concerns about ethical issues had increased at 49.5 percent of the agencies. The director at a program for the homeless stated: "We are ethically challenged," and another worker concluded that they were "on an ethical edge."

Human service professionals are also mandated to improve social conditions and promote social justice. Agency workers became "highly creative" in managing their ethical conflicts, sometimes going against the rules to help people survive. One worker explained: "We don't lie; we just creatively manage to try to get our folks what they need." At the same time, fear of reprisals or loss of funding from NYC officials left workers and administrators hesitant to publicly acknowledge their misgivings about welfare reform. They felt "gun shy" about speaking to the press and otherwise "tempered their vocal opposition" to the program.

Feeling Less Effective. Workers also began to feel less effective. While many people enter the human services with a strong desire to help, at 61 percent of the agencies, workers felt less able to help their clients than before welfare reform. A mental health agency supervisor declared: "We are dealing with a social service system that is supposed to work one way—to help clients—but it actually hinders them." According to the associate director of a teen pregnancy program, "The problems have become so intense that sometimes you walk away at the end of the day wondering if you did anything." A literacy agency program director mused that "sometimes I guess the workers feel like they are just putting Band-Aids on things."

Lack of Government Support. Workers also interpreted the loss of government funding and the new punitive regulations as a measure of government's lack of interest in their work and abandonment of their clients. The executive director of a preventive service agency explained that her workers "think that the system is against them, that they are trying their best to help families with no support." Elsewhere, some workers believed that political leaders "have declared war on the poor in so many different ways."

Burned Out and Stressed. It is widely known that when frontline workers bear the brunt of increased demands, speed-up, reduced job control, ethical dilemmas, and feelings of ineffectiveness, they can become emotionally and physically depleted, uncertain of their values, and unsure of the relevance of their organization (56–60). Although this study did not set out to investigate workplace stress, increased stress emerged as a major finding. The changes wrought by neoliberal welfare reform left many NYC nonprofit human service workers feeling dissatisfied, demoralized, and burned out. Job satisfaction decreased at more than 40 percent of the agencies, and morale decreased at almost 62 percent. The changes left some workers feeling, "Oh well, this is just a job."

An astounding 83 percent of the agencies reported higher burnout and stress among their workers since welfare reform. "We get less support from the system," explained the associate director of a teenage pregnancy program, "so the workers burn out much quicker." The director of the mental health division of a foster care agency indicated that "the punitive nature of this whole welfare reform increases stress and debilitates both clients and staff." As the associate director of an HIV/AIDS program observed, "People are working longer hours and they are more stressed out and there is more burnout. They get sick more." The director at a program for the homeless noted: "I know the stress levels are up because I can hear my staff sounding off more, swearing." Twenty-four percent of the agencies reported more requests for sick leave since welfare reform. One-third reported higher staff turnover. The executive director of a program for immigrants explained: "I am losing people. You have to be a real hard nut to be in this business."

The stresses linked to welfare reform do not bode well for workers or clients. Feeling demoralized, dissatisfied, burned out, and ineffective can affect a worker's health, mental health, and job performance. Burned-out workers often withdraw psychologically, lose their compassion for clients, and reduce their work effort (56). "If they don't feel good about their job, it is going to be hard for them to really help our clients," observed an executive director of a child care agency. To the extent that physical and emotional reactions to stress sweep through the nonprofit human service sector, the quality of *all* services suffers.

KwaZulu-Natal's Public Sector Hospital Nurses Try to Cope[4]

In 1978, world public health leaders developed an agenda for health care based on a commitment to primary care and a social view of health (62). However, the global economic crisis of the late 1970s and early 1980s undercut government investments in public health (63). The crisis forced many countries to borrow vast sums to cover debts incurred under far lower interest rates and to accept conditions on the loans that led to a loss of sovereignty over national policies, including health care.

In South Africa, the 1996 GEAR policy's focus on free-market economic growth diverted resources from initiatives that would have addressed long-neglected social welfare needs. In the years immediately following GEAR, social spending cuts as a percentage of the overall budget were accompanied by intensified annual job losses of 1 to 4 percent per year (31). At the same time, a movement on the right, promulgated by the World Bank and other international organizations, sought to replace comprehensive public health approaches with "selective strategies" that use "cost-effectiveness" as their primary measure of success. In short, they promoted the privatization of health care systems and disinvestment in public health in the developing world (63–66).

Recent labor shortages have compounded funding shortfalls in the health care sector. The combination of poor working conditions (intensified by the HIV/AIDS epidemic) and low pay has caused health care workers to leave their jobs in search of better pay and working conditions abroad. The resulting "global conveyer belt of health personnel" has also reduced the skill level of the workforce, enlarged the workload of health care workers, intensified burnout, and increased the risk of occupational injuries and exposures to HIV and TB and other infectious diseases (67). Nurse shortages also have disastrous consequences for patient care and constrain even well-funded efforts to combat disease. Following the implementation of GEAR in 1996 (the same year as enactment of welfare reform in the United States), KZN Province began to experience critical

[4] Original data for this section were collected and analyzed by Zelnick (61).

increases in illness, unemployment, poverty, and inequality (68). The province also became the epicenter of the HIV/AIDS epidemic that exploded between 1990 and 1996. Prevalence estimates based on measures in KZN antenatal clinics were as high as 37.5 percent in 2002 (69). As the HIV/AIDS crisis mounted, pressure on public hospitals and clinics in South Africa increased. At the same time, neoliberal policies—both International Monetary Fund conditions and GEAR's deficit-reduction program—constrained investments in the public health system.

A study involving nurses and administrators at three public hospitals in KwaZulu-Natal documents the impact of neoliberalism on health services (61). The three hospitals in the study represent historical and contemporary differences in the South African public health system. They include a district hospital located in a rural, former "homeland" that previously served an exclusively black African population; a regional hospital in a small town that in the past served an exclusively white population; and a tertiary care teaching hospital (referred to as a central hospital) located in an urban center and operated as a private-public partnership, which was built in the post-apartheid era. Today, public health facilities are segregated by economics (those who have insurance or can pay use private sector care) rather than by race (although the vast majority of poor people seeking public sector health care continue to be black Africans). At the time of the study, in May and June 2003, access to antiretroviral (ARV) treatment was not available for people living with HIV/AIDS; in response to a relentless social movement, universal access to ARVs in the public sector was made available in November 2003 (70).

Increased Demand. Demands on South African public hospitals increased with the HIV/AIDS epidemic, in terms of both the numbers needing care and the acuity of needed care. Studies in KZN have shown that in the late 1990s, AIDS became the most common reason for hospital admission (71), and admissions rose dramatically (72). An AIDS clinic nurse described the increases in admissions and acuity: "The number of HIV+ patients is increasing, more and more are positive, most are TB positive." As a maternity nurse explained, "Patients come in with so many problems, and also psychological problems. The patient is weak, sick, stressed. It all has to be attended to."

In 1996, 45.4 percent of people in KZN were classified as "living in poverty"; by 2001 the number had grown to 49.9 percent (68). The combination of HIV prevalence and poverty has resulted in demands that hospitals are ill-suited to fulfill. According to a hospital manager at the regional hospital, "The severity of the illness has had a huge impact on our hospital. AIDS patients are severely, severely ill. They take longer to recover, so the length of stay is longer. If they are in the end stages—we have a large population of terminally ill patients—we need not to be treating them, because this is an acute care hospital, But these patients come from such terrible financial circumstances that there is nowhere to

discharge [them] to, it would be inhumane." Due to the failure to develop strong HIV/AID policies, hospitals end up filling the void left by the insufficiency of hospice programs and other community services for AIDS patients.

Increased Work Intensity / Speed-up. In the context of increased demand, staff shortages have contributed to increased work intensity and speed-up among nurses. Both nurses and hospital personnel in the study agreed that low salaries and international migration led to staff shortages. In 2003, the district hospital reported that 41 percent (65/158) of nursing positions were vacant, the vast majority (44/56, or 68% of the total) at the highest skill level. The regional hospital had a vacancy rate of 7 percent (25/344) for all positions, the majority (60%) also the most highly skilled. While the tertiary hospital reported no shortages (it was still opening up new units at the time of the study), it relied heavily on rehired retirees, who accounted for a full 12.5 percent of the 1,148 nursing staff. Nurses in the rural hospital left for urban areas, while others signed on with recruiters, often leaving their posts in the public sector without notice. One administrator bemoaned that "last month I nearly tore my hair apart because I had 5 resignations in one day, all in one day! You are thinking, how am I going to fill this post, how will I provide patient care?"

Nurses blamed low pay for the staff turnover and shortages: "It's the salary: people don't want to work for this salary." A national central bargaining council sets the salaries of South African public sector nurses and other public employees so that pay does not vary between hospitals. Salaries for public sector hospital nurses are low compared with those of their counterparts in the private sector and abroad. At the time of the 2003 study, staff nurses in South African public hospitals earned the equivalent of US$7,000, on average, compared with an average of US$17,000 in the South African private sector; their U.S. counterparts earned an average of US$40,000 (73).

Picking Up the Slack / Coping. With turnover high, the nurses who remained were left to pick up the slack. To compensate for staff skill shortages, all three facilities in the study rehired retired nurses on a contract basis as a stop-gap measure. Hospital managers explained that returned retired nurses "are struggling" and "don't have enough resources" in retirement, indicating the impact on retirees of inadequate salary and pensions and rising costs. Another manager explained that the work of retired nurses is "the only thing that has helped us survive, because of them we are coping."

Nurses also had to cope with equipment and space shortages. At the district hospital, the lack of many skilled professionals compounded other resource deficits. The nurse manager at the district hospital, a 37-year veteran, described how, due to equipment shortages and lack of key medical personnel, cesarean deliveries, minor surgeries, and routine procedures such as resetting broken

bones could no longer be performed, though all of these were done in the past. Recurring outbreaks of cholera at the district hospital between 2001 and 2003 had commanded health department attention (74), but during data collection for this study, infants hospitalized for diarrhea but not yet diagnosed were sleeping three to a crib, creating a serious potential for cross-infection. The hospital manager at the regional hospital spoke of the "terrible strain on resources" and the significant challenge of providing "quality care when you don't have the personnel to provide it."

Demand Shift / Ethical Dilemmas. Because the government had provided neither sufficient resources for health care needs arising from the HIV/AIDS epidemic nor a strong policy on HIV/AIDS, hospitals had to meet shifting demands. Every day, they met with ethical dilemmas that stemmed from contradictions arising from providing government-sponsored health care, a rampant epidemic of HIV/AIDS, and a government stance that denied the key realities of HIV/AIDS. During the 1990s, the Mbeki-led administration failed to take action to combat HIV/AIDS, while President Mbeki himself publicly expressed doubt that HIV caused AIDS (75). Lacking government action, the hospitals were left to deal with the huge numbers of untreated patients, opportunistic infections (especially TB), and stigma and denial of the disease (72). A medicine nurse explained the negative impact on patients of the government's stance: "When someone like the president tells people that AIDS isn't the killer . . . people think, why should I wear a condom?" Another nurse added: "Our government here . . . tells people that AIDS is caused by poverty, so we definitely know these people don't care."

Another ethical dilemma was posed by the disparities in resources among the three hospitals in the case study. For example, the equipment used for safe disposal of needles, intended to protect staff from accidental exposure to blood-borne pathogens, varied from one hospital to the next. At both the district and regional hospitals, the containers used for needle disposal were made of thin, easily punctured plastic. The lids could easily pop off or be removed, and buckets holding used needles could easily overflow. In sharp contrast, the central hospital had access to state-of-the-art needle disposal systems made of hard plastic and designed to prevent overfilling. It also had other protective devices, such as needle-less systems. As a result, nurses at the central hospital received better protection against accidental sharp injuries and blood exposure. The central hospital possessed resources that helped it recruit and retain staff, such as desirable accommodations for nurses (including some family units), location in an urban area, and a modern work environment. Thus the central hospital held a competitive advantage over the district and regional hospitals in recruiting local staff. In sum, the advantages held by the central hospital placed nurses and patients at the district and regional hospitals at a disadvantage for healthy and safe working conditions and quality care.

Lack of Government Support. In addition to the low salaries and staff shortages that contributed to a challenging work environment, nurses felt they were doing important work and incurring significant health risks, but lacked support from the national Department of Health. In the words of a sympathetic manager: "the government and Department of Health do not do enough for us or the patients, though the hospital might wish to." In a group interview, medicine and maternity nurses agreed that "others such as firefighters and the military are compensated for their risks, we aren't recognized." Nurses (and some administrators) held the national Department of Health, where salaries are set and policies made, responsible for most of these problems.

The lack of sufficient national AIDS policy at the time of the study was one of the most potent issues for patient care. Nurses and administrators shared the view that medication to treat HIV/AIDS should be made universally available in the public system. Nurses on the frontlines of the epidemic witnessed how people were "dying like anything, especially the youngsters." At the same time, it is worth noting that once ARVs were made available in late 2003 (after the study period), the impact of staff shortages became the key issue in delivering care and treatment, as the additional task of providing and monitoring treatment was added to the workload at public hospitals and clinics (76).

The many issues that surrounded the nurses' own health and safety were also related to the government's neglect of HIV/AIDS policy. Insufficient attention and support for HIV-positive nurses created serious health risks in the context of rampant TB. In the words of a health and safety nurse: "Another huge problem is HIV+ staff having to nurse patients with TB . . . there are no safe areas to put them in, so the staff is just appointed as if no one is affected." The district and regional hospitals, where HIV/AIDS and TB were concentrated, had serious shortages of equipment (gloves, safe needle devices), faulty equipment (needle-disposal buckets that popped open or could become punctured), lack of appropriately trained health and safety staff, and lack of space to ensure confidential services (of critical importance for nurses whose injuries require them to have an HIV test). The fact that protective equipment, a computerized system for confidential HIV test results, and a well-appointed occupational health clinic were available in the state-of-the-art tertiary care hospital that received more government attention and support underscored the neglect of the other hospitals.

Feeling Less Effective, Burned Out, and Stressed. Hospital staff shortages resulted in reduced care levels, poor working conditions, and increased stress. Due to shortages in adult medicine in the district hospital, one nurse per shift took care of 20 patients for 8 hours, 7 days a week (3 nurses for each of three shifts for a 20-bed ward). In the regional hospital, 4 nurses did the job of 12 on the maternity wards. Nurses described how they were "stressed' and "rushed, trying to do too much because we are short staffed." Despite the oft-mentioned logic of seeking higher pay overseas, nurses also described the considerable social cost of leaving

home: "Nurses who leave for overseas sacrifice everything—their families, children, husbands, and homes—but they must go because they need the money." Commenting on operating with short staff and tough conditions, the manager at the district hospital reflected: "If you try to stretch the few people you have, they get burned out and leave. So you need to stretch them to a reasonable state."

Caring for HIV/AIDS patients under these working conditions stressed nurses and challenged their professional role. Maternity nurses also described how the stigma and denial associated with HIV/AIDS led to secrecy about one's HIV status, which became another source of stress. "When a woman came to give birth it used to be a celebration. Now if the mother is very sick, there is little excitement. They should come two to three months ahead, but now they just stay in their house until they are ready to deliver; they don't want to be talked about." Maternity nurses discussed how fear of discovering they had HIV/AIDS led young women to avoid prenatal care. This resulted in a host of patient complications and made the job of already stressed maternity nurses even harder. Robbed of the joy of helping people with births and recovery that had once accompanied their jobs, maternity nurses frequently left their positions, creating increasingly hard-to-fill vacancies.

DOUBLE JEOPARDY: CREATING THE POTENTIAL FOR RESISTANCE BASED ON SHARED INTERESTS

The goal of caring service work is to help people improve their lives, assist the poor, sick, and vulnerable, and contribute to positive social change. The failure to meet these goals is a source of stress unique to health, human service, and other care workers. Motenko and coauthors (38) suggest that there is a cycle in which "underfunded services" lead to the "inability of service providers to provide effective services," which then "exacerbates client problems." To this treacherous cycle must be added the adverse health and mental health effects on caregivers that make the mission to provide care that much more difficult to fulfill.

The combined findings of the two case studies described here point to the destructive power of neoliberalism, but also to the potential for resistance based on shared interests. Despite enormous differences between the two countries, in both cases, neoliberal policies increased the stress of personnel, decreased the capacity of institutions to provide care, and reduced the well-being of individuals and families. In both NYC and KZN, care workers reported similar working conditions, including speed-up, time pressures, staff shortages, and loss of control over their work, as well as feeling frustrated, unimportant, demoralized, unsupported, and/or powerless. In both locales, serious stress was on the rise, and workplace tension took a toll on life outside work, A NYC social worker stated: "The problems are just too big. The workers can't leave them at the office. They take them home and it is affecting their private lives" (41). In similar terms, a surgical nurse in KZN lamented: "This disease [HIV/AIDS] also affects our social

lives. We work with this every day, and we read the stories in the paper. We become more afraid, we find ourselves sitting at home. It makes our life miserable" (61).

In the United States, the economic boom of the late 1990s opened more jobs to women receiving welfare, easing the pressure on human service workers in New York City, as did the enormous drop in the welfare rolls. But the pressure to move people from welfare to work continues. Meanwhile, slowed economic growth in the early 2000s and the economic meltdown of 2008 may eventually cause welfare rolls to rise. What remains to be seen is whether the Obama administration and the U.S. Congress offer clients and workers a new "New Deal" or simply more of the same. In South Africa, a coalition within the ANC succeeded in replacing Mbeki as ANC leader (December 2007), largely on the grounds of the neoliberal policies and their effects on the working class. In September 2008, Mbeki, along with other key proponents of neoliberalism in his administration, were ousted from South Africa's leadership, a further victory for forces led by the trade union movement—with key participation by the National Education Health and Allied Workers Union (NEHAWU), which represents many public sector nurses. While this political shift has already led to changes in the health ministry that bode well for treating HIV/AIDS, it remains to be seen how, amid competing demands, the new political leadership will address the situation for public sector nurses.

Neoliberalism's faith in market forces and its disdain for government support seem to have overridden major differences between the two countries and among service providers in these case studies. The similar experiences of both vulnerable client/patient populations and care workers resulted in "double jeopardy," revealing intimate links between providers and the people they serve. This double jeopardy is also evident in the parallel impacts for workers in South Africa and the United States. But the potential for resistance to neoliberalism was more fully realized in KwaZulu-Natal than in New York City.

A NYC human service worker explained that welfare reform acted as a wake-up call, shaking complacent workers. She declared: "Welfare reform has brought us back to the mission to advocate for the rights of the client we are serving" (41). While a renewed commitment to advocacy led social service professional organizations to seek less harsh legislation, the major U.S. movements virtually ignored the clients and human service workers who suffered the neoliberal assault. The only exception was a revival of the welfare rights movements that had been active in the late 1960s and early 1970s. But they, too, failed to win support from other social movements, and before long their organizing converted to legislative advocacy.

In stark contrast, in KZN, nurses and other public employees made history when they launched a 28-day national strike (June 2007) over salaries and working conditions, which closed down hospitals and other public services. Six months later, subsequent negotiations resulted in wage increases of between 20 and

80 percent for public sector nurses (77). Through the trade union movement, nurses have also played a role in political change that has disempowered the main proponents of neoliberalism in the national government.

In the final analysis, more than a few human service workers and nurses became partisans in the social conflict that neoliberalism regularly generates. However, in South Africa, the victory in the struggle against apartheid, the presence of a wider range of political views in government, and the strong alliance of grassroots social movements provide a more fertile ground for social actions aimed at policy change. For example, the Treatment Action Campaign, a grassroots social movement partnered with COSATU, the largest trade union federation in the country, has taken up the cause of public sector nurses from the perspective of the human rights of people living with HIV/AIDS and the constitutional right to health care.[5]

Occupational health and safety has sometimes been a narrow field, sheltered from public view by the private workplace and scientific debate about causality. The shared interests of care workers and the people they care for in the "fight-back" against neoliberalism suggest the potential for aligning care workers' health and safety with client/patient needs in public policy formation. The health and safety of care workers in the global economy is an important dimension for evaluating public policies and envisioning better ones.

Acknowledgment — The U.S.-based research was funded by United Way of New York City and sponsored by the New York City Chapter of the National Association of Social Workers.

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[5] This difference could also be described in terms of variations between social services and health care in the United States. During the 1990s, health care workers, including nurses, organized in great numbers and at times militantly in response to working conditions (in labor unions, including the Service Employees International Union, the California Nurses Association, the Massachusetts nursing association, and the Federation of Nurses and Health Professionals). The same cannot be said of human service workers in the United States. While many public sector welfare and child welfare workers are part of labor unions, organizing has been far less successful and widespread in human service agencies.

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