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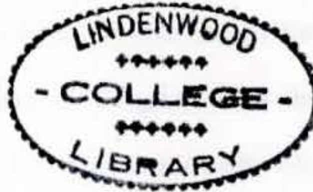
The Health Care Industry
Union vs Management

Maria Ciolfi



An Abstract presented to the Faculty of the
Graduate School of Lindenwood College in
Partial fulfillment of the Requirements for the
Degree of Master of Science
1990

Abstract

This paper will begin with an overview of the legal enactments which allowed the National Labor Relations Board (NLRB) jurisdiction in the health care sector. It will discuss the development of the reimbursement system, technological advancements and their effect on the health care industry.

Based on these developments, several human relations issues have emerged resulting in union activity in the health care environment. A dichotomy arises when both management and labor strive for high quality patient care. Management is forced to operate within cost constraints, leaving labor to battle for equitable wages and benefits in the third largest industry in the United States.

The major point will be the ramifications of this activity as it affects the workers it represents and management's operating cost.

The election activity of unions will be analyzed as it relates to profit or non-profit organizations following the impact of the 1974 amendments to the Taft-Hartley Act. Also, new developments in marketing strategies will be examined as labor focuses on community support while management focuses on employee relations.

Future legislative factors will be reviewed discussing their impact on labor involvement in the health care industry, adding management and labor viewpoints on the health care crisis.

Finally, the author will provide opinion in the situation and offer suggestions for the future role of union and management in the industry.

The Health Care Industry
Union *vs* Management

Maria Ciolfi

A Culminating Project Presented to the Faculty of the Graduate School of Lindenwood College in Partial Fulfillment of the Requirements for the Degree of Master of Science
1990

c 1990 Maria Ciolfi

COMMITTEE IN CHARGE OF CANDIDACY:

Assistant Professor Susan A. Myers, Ph.D.
Chairperson and Advisor

Assistant Professor Joe Ancona

Adjunct Assistant Professor Jerry Schwartz

Acknowledgements

It is my personal philosophy that everyone we meet, especially those with whom we develop close associations, have an influence on decisions we make and directions we take during our life.

Every now and then I have been lucky enough to come across extra special people; the ones who appreciate the positive and tolerate the idiosyncracies of my personality above and beyond the realms of normal friendship. I am very fortunate, professionally and personally, to have a strong support system of family and friends. Listing their names would take pages and since this section is not numbered in the manner that extends this text, I was advised against it.

To those who have offered support and friendship to me, and especially those who have advised and assisted in writing this project, I extend my heartfelt thanks.

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Chapter I

Introduction

The maze of the health care system is an all too familiar one. The issue of union organization in the health care industry is a strong contender for what appears to be a "which way to turn now" situation.

Management contends that although the union ideals might be preferred, they are unrealistic and utopian for this free enterprise and capitalistic nation. However, unions contend it is imperative that the health care system begin taking care of its providers. Union officials believe this can be accomplished realistically through new legislation, implementing a cooperative enterprise among health care facilities and a recognition from the industry that there has to be a change.

Literature Review

Legal enactments. As early as the 1890's the labor force was trying to pave the way for industrial America. With strong opposition from management, unions fought to achieve fair treatment, higher wages, and better benefits for "the people." However, it was not until 1935 when legislation passed the Wagner Act or the National Labor Relations Act allowing workers the right to organize and collectively negotiate with employers. This Act was the primary statute governing labor relations in the United States. It specified the employers rights and responsibilities during the bargaining process and identified such practices as coercion, unfair labor policies, discrimination and not bargaining in good faith (Becker & Rakich, 1988).

In order to avoid unethical practices by labor/management operations, the National Labor Relations Act established the National Labor Relations Board. Its primary function was to review and resolve unfair labor practices and oversee union election activity. This also resulted in the development of the Taft-Hartley Act in 1947 to

correct the imbalances of the original National Labor Relations Act and elaborate specifics of the bargaining unit. An example includes: professionals, non-professionals and guards not being categorized in the same bargaining unit because their needs were too diverse. However, the Taft-Hartley Act neglected to include certain corporations such as government agencies, and most of the nations hospitals were excluded from the coverage (Becker & Rakich, 1988).

For the next 25 years several battles were fought between union and management with unions victorious and becoming extremely powerful in the industrial work force. Through all this very little attention was focused on the health care industry and its providers.

With the election of President Kennedy in 1960, a gradual shift from industrial issues to health care issues began to emerge. In 1962 the National Labor Relations Act was modified by Executive Order 10988. This allowed collective bargaining in the Federal Service Agencies with a "no strike clause" addendum. However, non-profit health care facilities were still not addressed. Nearly half of

the nations hospitals were still not covered under any federal legislation and over 1.5 million hospital employees were affected (Becker & Rakich, 1988).

It was not until 1974 that non-profit hospitals went under the jurisdiction of the National Labor Relations Act through the enactment by Congress of the Non-Profit Hospital Amendments to the Taft-Hartley Act. This was very significant because prior to this most states failed to enact laws to regulate hospital union activity. The laws varied from state to state and as a result most hospitals were not covered by the National Labor Relations Act until the 1974 legislation.

Major Issues Impacting the Health Care Industry

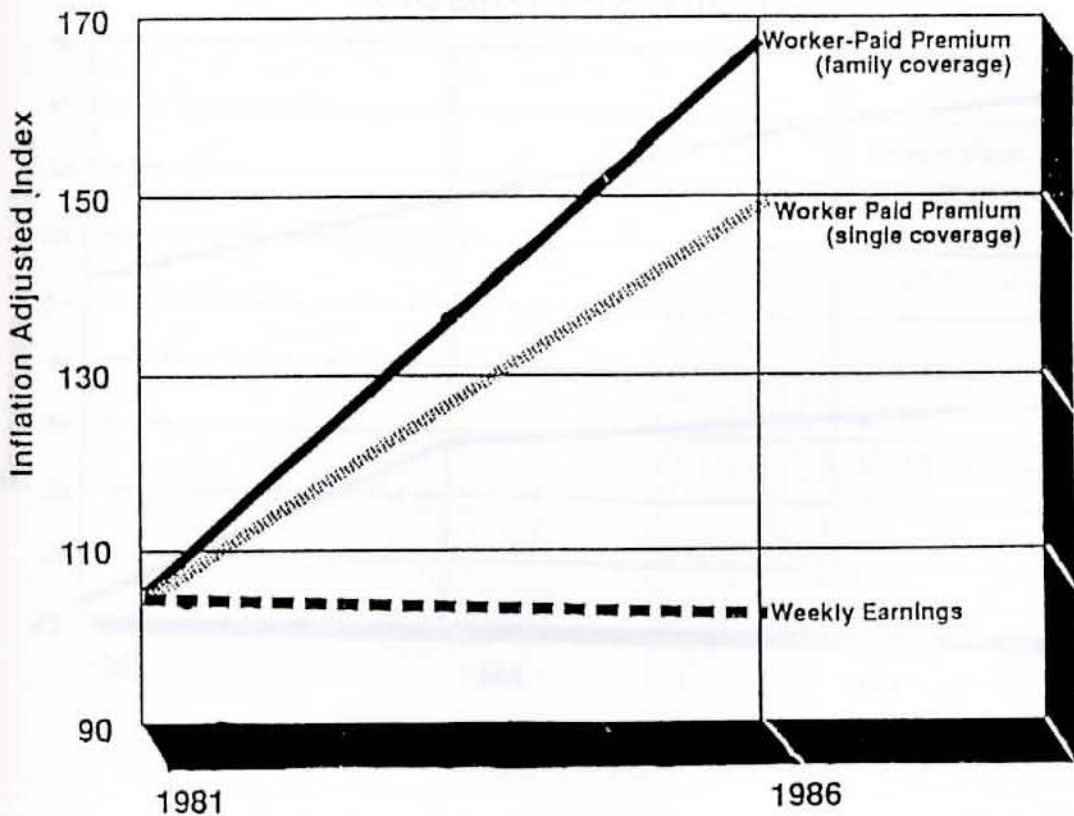
Reimbursement system. To quote the infamous phrase from the musical Cabaret, "Money makes the world go around." This is particularly true in the health care industry where providing a service became operating a business. As a result, the cost of coverage has shifted. For example, prior to the 1960's employees were responsible for paying for

their own insurance. Costs were reasonable and the average worker could afford coverage.

During this time federally sponsored programs such as Medicare/Medicaid were established and employer-paid benefits became the norm. This action became known as cost-shifting. This trend continued throughout the 1980's but "health care costs far outpaced economic growth, general inflation, and family incomes" (Service Employees International Union AFL-CIO, 1990), (see Table 1). Eroding employer-paid coverage became the biggest threat of all. The cost for insurance has become so high that now employees have to share the responsibility of payment (see Table 2). With the increase in unemployment and the expanded use of part-time or temporary employees (see Table 3), employment-based health insurance is undermined. Consequently, thirty-seven million Americans lack health care coverage (Employee Benefits Research Institute, 1990). The significant rise in health care costs has been attributed to such facts as technological cost, an aging population with health problems, defensive medicine, excess capacity and an increasing number of well-trained specialists

TABLE 1

Worker health insurance premiums are going up faster than wages.



*Note: Wages are for private, non-supervisory workers in all industries

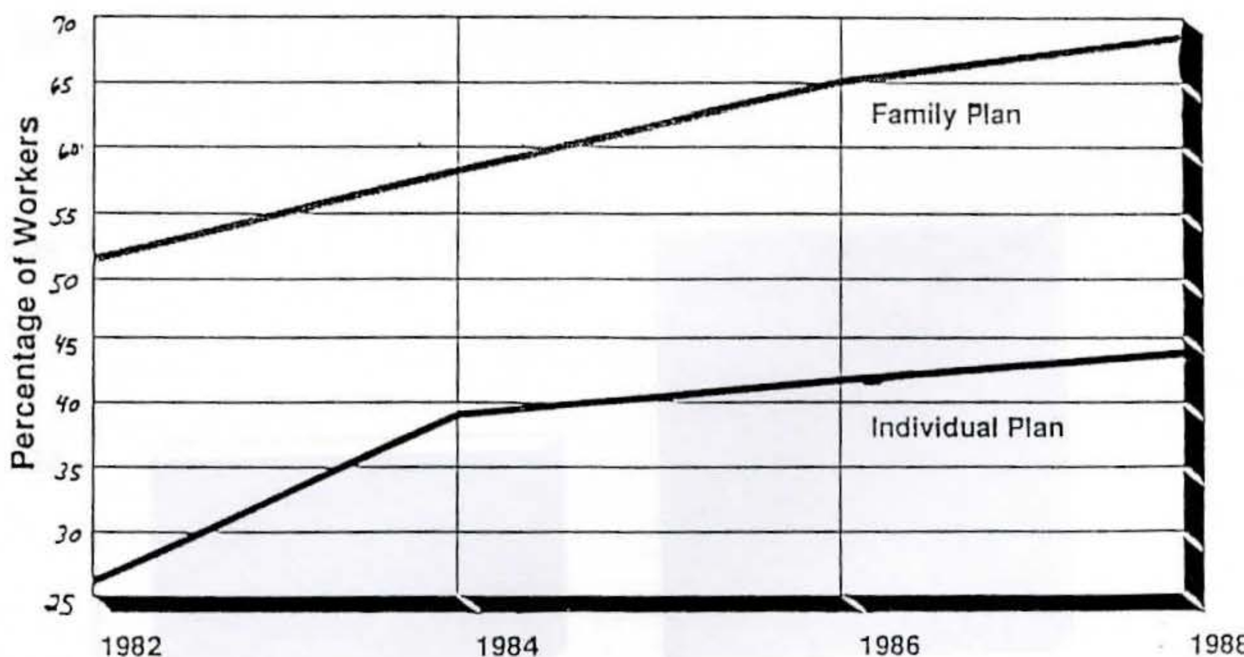
SOURCE: *BLS*

Service Employees International Union, AFL-CIO, CLC

TABLE 2

Employers are shifting health care costs to workers.

Workers Paying a Portion of Health Premiums

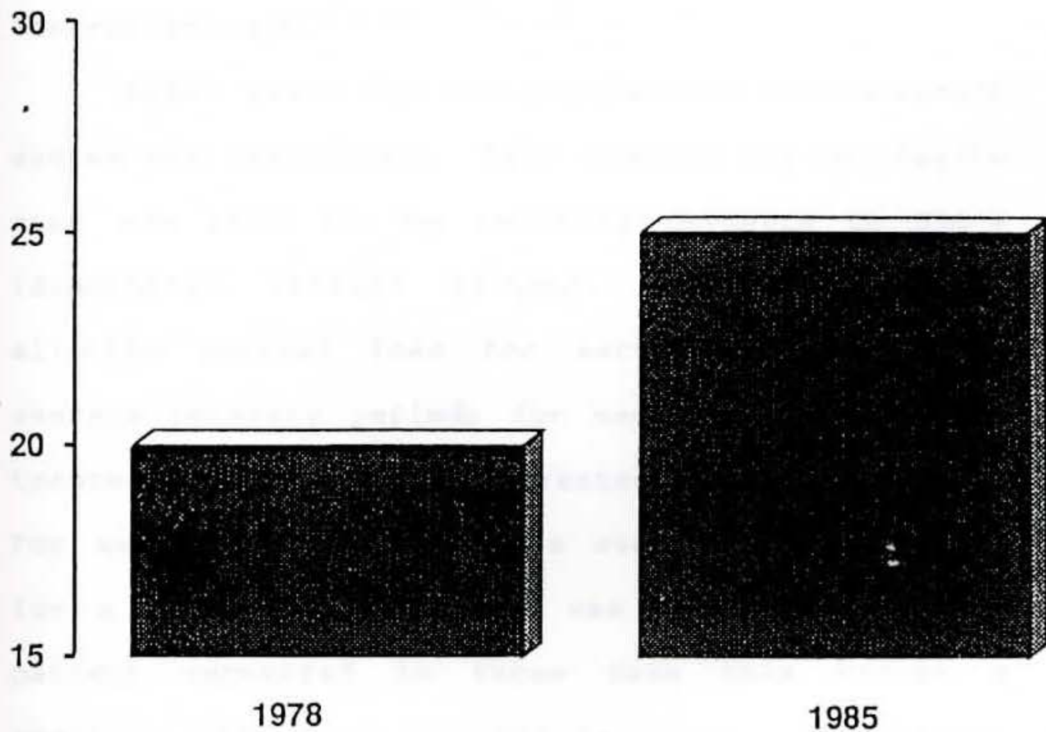


SOURCE: *SEIU Public Policy Department*

TABLE 3

Part-time hospital employment is growing.

Part-Time Workers as a Percent of All Workers in U.S. Community



SOURCE: *Bureau of Labor Statistics, Hospital Industry Wage Survey, 1978, 1985*

demanding higher wages (Smith-Daniels, Schweikhart & Smith-Daniels, 1988).

To combat these rising costs government has enacted cost containment fixed-price payment reimbursement methods for the Medicare/Medicaid programs. Employers have imposed deductibles on insurance plans, HMO's (health maintenance organizations) and PPO's (preferred provider organizations) have sprung up as independent corporations to meet the demands for better controlled cost.

Eight years ago the prospective reimbursement system was introduced. This changed the way health care was paid for by relating payments to DRG's (diagnostic related groups). Facilities were allotted nominal fees for services rendered and average recovery periods for each diagnostic group treated. This situation created several problems. For example, if a patient's average recovery time for a particular treatment was five days and the patient recovered in three days this became a positive cash flow for the facility. Conversely, early discharge became prevalent with full patient recovery not necessarily a priority. Besides

limiting revenues, another effect of the prospective reimbursement system was the limiting of in-patient admissions. Obviously out-patient cost is less expensive than in-patient cost for the same treatment (see Tables 4 & 5). This is a logical phenomenon of fixed-priced services. The problem for health care administrators was that this change in patient mix reduced revenue while costs increased (Hanks, 1988).

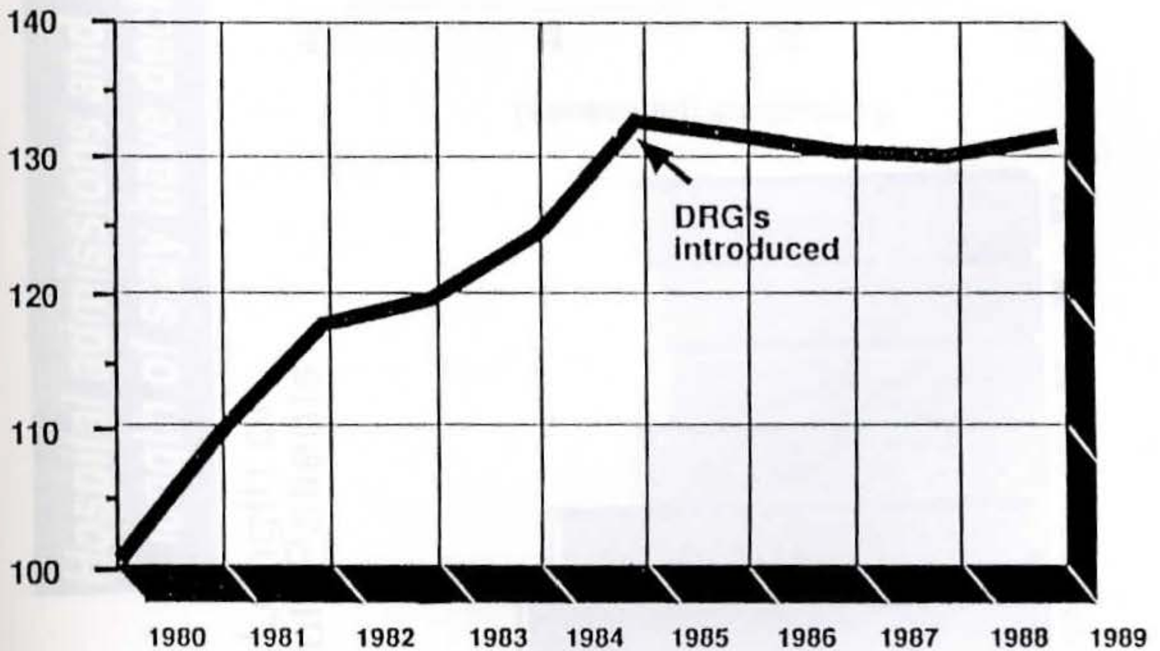
Under the current established guidelines by Medicare, providers are paid for the Medicare portion of the capital related costs such as depreciation, taxes, interest expense, etc., (Maier, Benton & Hamilton, 1988). Because Medicare plans to combine in-patient costs into the prospective payment systems, effective October 1, 1991, health care organizations are evaluating their capital expenditure plans. The object is to maximize payments under the current system by creating the highest cost up front.

Adding to these dilemmas, government reimbursement has not kept pace with inflation. In 1989 the gross national product rose about five percent and health care expenditures increased about

TABLE 4

Rapidly rising costs forced Medicare to limit payments for in-patient care.

Medicare Payments per Enrollee



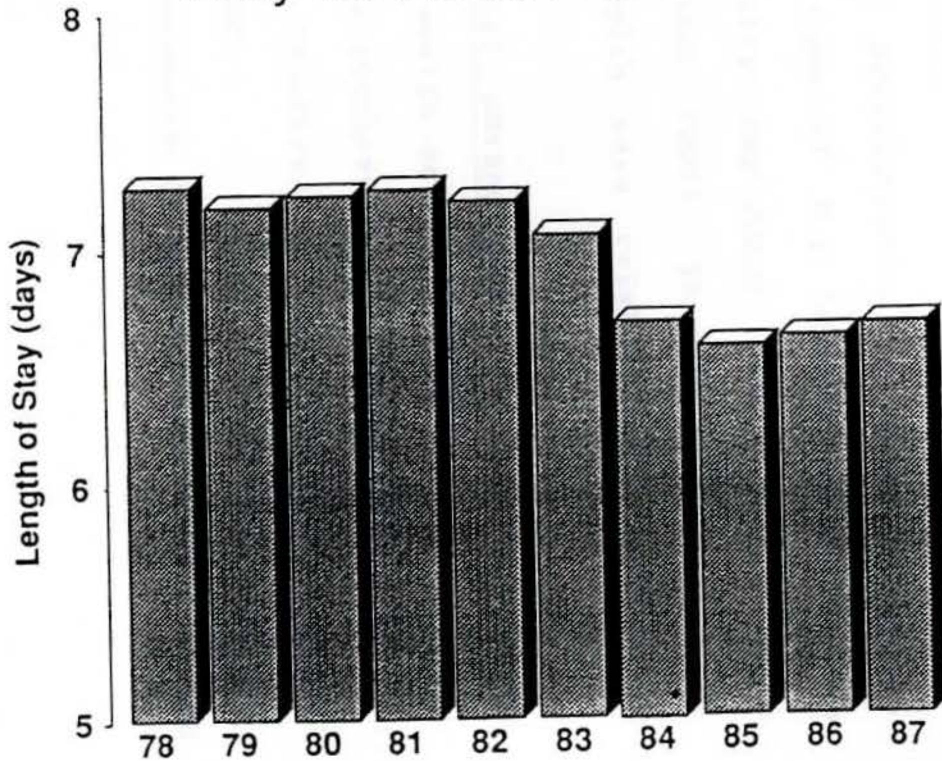
SOURCE: *HCFA*

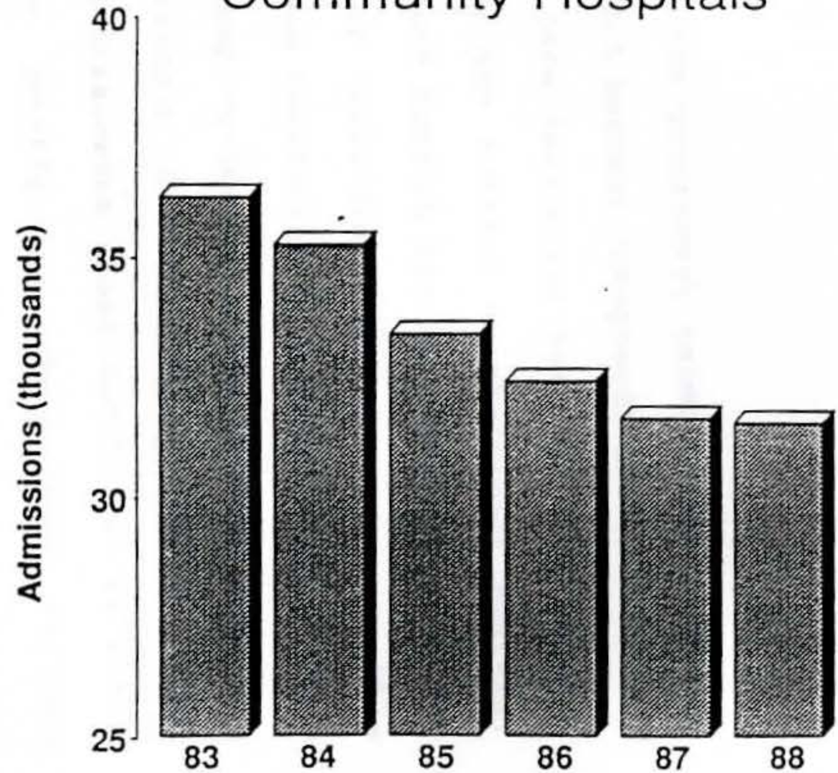
Service Employees International Union, AFL-CIO, CLC

TABLE 5

Hospital admissions and length of stay have declined.

SOURCE: *AHA, 1989, Hospital Statistics*





ten percent to the government reimbursement rate of approximately 3.5 percent (Shepherd, 1988).

Long-term care facilities have an even greater challenge from the current reimbursement systems. Medicare/Medicaid funding has not begun to cover the total cost of providing patient care. This situation forces facilities to subsidize these costs with private pay residents and community resources which are difficult to obtain (Lutz, 1987). Also, hospitals are pressuring these facilities to accept patients more quickly and admit those patients requiring more care.

The current administration is proposing budget cuts to the tune of 8.2 billion dollars from Medicare (Service Employees International Union AFL-CIO fact sheet, 1990). To what degree this will effect the health care reimbursements system is unknown.

<u>Technological advancements</u>. "The impact of technology on health care costs has been a dominant issue for those involved in formulating policies and governing the organizations and financial systems" (Whitcomb, 1988).

With advancements in medical technology, health

care facilities are faced with the decision of providing patients with the most advanced equipment available, while trying to control cost at the same time. The financial effect of modern technology under the current reimbursement system is profound. One example that illustrates the financial implications of new medical technology is the introduction of thrombolytic agent-tissue plasminogen activator (TPA). TPA dissolves blood clots in acute myocardial infarction cases. This procedure is up to 30 percent more effective than traditional treatment but on average costs $2,100 more per dose.

Medicare's present reimbursement rate for acute myocardial infarction cases is approximately $600 per day. For a typical facility, expenses could increase by $431,200 annually for this one technological advancement (Shepherd, 1988).

The differences between controlling the assessment and use of technological equipment causes dissention within the professional and financial structure of a health care facility. A conflict exists between those who believe that the decisions regarding the use of technology should be left

solely to the physicians and those who believe that it should be regulated by others to ensure the most cost effective use of these resources. Because of this conflict, "utilization of high-tech equipment has become a financial and clinical issue" (Shepherd, 1988).

Since Medicare is such a substantial payer of medical services, it is important to also consider how the Health Care Financing Administration (HCFA) policies affect technological issues. During the past 15 years health care technology has been addressed from a number of vantage points. We are now at a stage where private sector incentives dominate technology assessment. The ultimate role of government will depend on whether the varied interests of the professional and private sector organizations will converge in the interest of the public. If not, the government will approach the assessment of technology from a regulatory standpoint in an effort to contain health care cost.

Employee issues resulting from the health care crisis. Budgetary structuring in the health care industry has created an atmosphere of conflict and discontent among providers. Based on the new

developments in technology and limited funding several issues have emerged resulting in a dichotomy. Facilities are re-evaluating employee benefits in order to operate under the cost constraints imposed by State and Federal regulations. According to Raymond F. Mickus, President of Mickus and Associates, a management consulting firm, the following human relations issues are direct results of this conflict:

1. Bricks and mortar versus people;
2. Staffing: shortages and reductions;
3. Dignity and self-worth;
4. The "confounding" employee survey;
5. Pay for performance and evaluations;
6. Cost containment and quality;
7. Empire building;
8. Changing leader styles;
9. We don't talk anymore.

Bricks and mortar versus people. Legislation is focusing more and more on appearances of facilities rather than on quality of care. For instance, the State of Illinois recently allocated funds to improve the image of nursing homes. While it is not a law to provide adequate living conditions such as cooling systems, it has become a priority to reward facilities for improving their aesthetics. The dilemma of low wages and poor benefits continues to be ignored and it is very difficult to hire and

maintain a quality staff.

Staffing: shortages and reductions. Because the reimbursement system does not provide adequate funds, facilities are forced to cut staffing to a minimum. This results in employee fatigue and an increase in absenteeism. In addition, staff is required to work longer shifts in unfamiliar areas causing an increase in stress and frustration levels (Mary Beth Ryan, Missouri Nurses Association, personal communication, 1990).

Dignity and self-worth. Most decisions affecting job policies and procedures are made at a management level not involving those directly effected by the results. This causes the employees to feel unimportant and exploited. Also, due to the shortage of nurses, management tends to cater to their demands neglecting the needs and concerns of other employees (Mickus, interpersonal communication, 1989).

The "confounding" employee survey. Employees surveyed revealed that some of the most important problems were lack of upward mobility, inadequate feedback and limited follow through. Most departments are not structured to accommodate upward

mobility. "Promotions" were often lateral moves and because of layoffs, job assignments increased without pay compensation. In addition to undertaking the extra work load, staff felt they were often criticized for a poor job and rarely praised for a job well done. Lack of supervision and follow through regarding present job performance or newly implemented procedures caused uncertainty, unnecessary mistakes, lax behavior and negative attitudes (Joe Ancona, Ancona & Associates, personal communication, 1990).

Pay for performance and evaluations. Pay increases are often not based on job performance but rather on seniority or cost of living. Therefore, there is no incentive or motivation for staff. Performance appraisals become meaningless as a result of favoritism by evaluators (Joe Ancona, Ancona & Associates, personal communication, 1990).

Cost containment and quality. Due to the budgetary constraints, health care facilities are forced to reduce staff and benefits. This creates an atmosphere of stress among providers. Their work load is increased, yet they are still required to spend "quality time" with each resident. This

quality time is affected as most providers are forced to acquire second jobs to compensate for the salary and benefit reductions, leaving them fatigued and prone to job "burn out" especially in long-term care settings.

Empire building. This situation is all to common in the health care industry. Often executives/managers salaries are disproportionate in relation to the facility size, number of filled beds, and the actual care givers salaries (Mary Beth Ryan, Missouri Nurses Association, 1990).

Changing leader styles. With the high staff turnover in health care facilities, consistency and stability are not customary. With every new leader there are new ideas and plans of operation to be implemented. Often there is little or no regard for understanding this changing environment (Mickus, interpersonal communication, 1988).

We don't talk anymore. Often employees feel that their concerns are not heard or important because they are not included in the decision making process. The handling of problems frequently goes unresolved or are put on the "back burner." This lack of involving employees creates an atmosphere of

suspicion and poor morale.

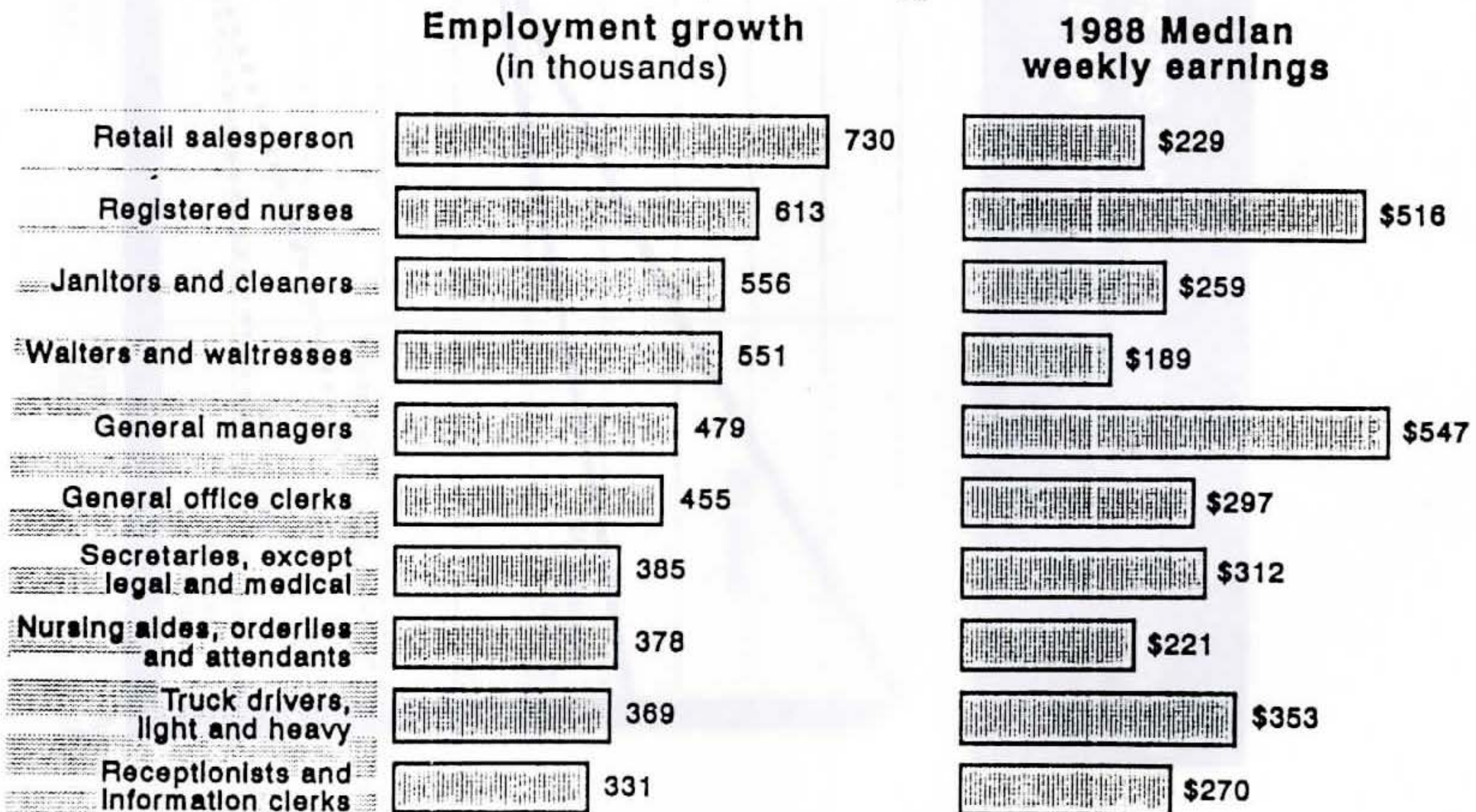
The health care system is undergoing restructuring of a radical nature. People who provide and receive care are bearing the brunt of this change. It is one of the fastest growing occupations and one of the lowest paid (see Tables 6 & 7). In the past quality of care dictated decisions. Today, new priorities influence health care managers' choices. Containing costs and generating profits now equal or exceed the issues of patient access and quality of care (Savage & Blair, 1989). This results in what is perceived as a compromise of professional and personal ethics by managers towards their employees, which opens the door for union activity.

Union Involvement in the Health Care Industry.

Union election activity. "Health care is for the unions today what the auto industry was in the 1930's" (Harley Schaiken, labor economist, University of California, San Diego, 1988). Since the National Labor Relations Board was amended in 1974 to include not-for-profit hospitals, "employees have voted to unionize in 51% of representation elections at all hospitals both non-profit and

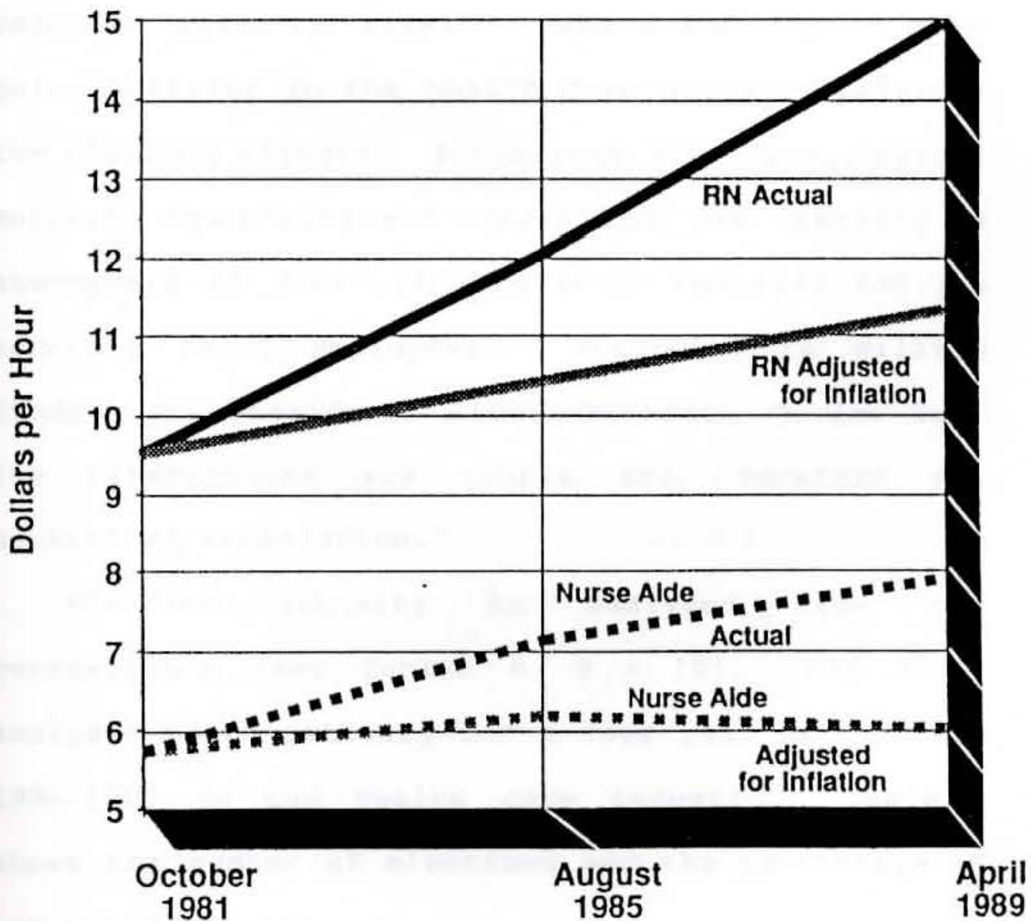
TABLE 6

Fastest growing occupations in the 1990s are mostly low paid



Source: Bureau of Labor Statistics - Earnings for full-time wage and salary workers

TABLE 7



SOURCE: *Bureau of Labor Statistics, Industry Wage Survey*

Service Employees International Union, AFL-CIO, CLC

for-profit. From 1974 through 1988 health care employees working in all forms of health care operations voted to unionize 51% of the time" (Burda, 1988).

The health care system is run hierarchically as much like a factory as an office. However, health care employees are used to working together more than other types of laborers when the need to unionize presents itself. The trend toward more union activity in the health care industry reflects the changing climate. Situations like deregulation, mergers, downsizing and competition are creating an atmosphere of panic in regards to benefits and job security among employees. According to William Stodgehill, President, Local 50 SEIU, "a few feel the alternatives are viable and therefore are seeking representation."

Election activity is analyzed from two perspectives (see Tables 8, 9 & 10). The first analyses union activity for a four year period from 1984-1987 in the health care industry. Table 8 shows the number of elections and the percentage of union wins by the year

Table 8

Health Care Component of Service Industry

	% of Union Wins	# of Elections
1984	59.4%	360
1985	53.6%	323
1986	52.0%	354
1987	56.2%	201

*first three quarters

Sources: Raymond F. Mickus & Associates, Inc.
Management Consulting Firm

Table 9 is a breakdown of the year 1987 in the previous chart and compares the health care industry to nine others, adding a table of the decertification for the same industries. The second approach analyses union activity in non-governmental health care institutions for two 64-month periods. It breaks down hospital characteristics and union election features (see Table 10).

From 1984-1987 there has been about a 55% decline in hospital union election activity. Gerry Shea, director of the health care division of the SEIU, Washington, said:

TABLE 9

1987 Elections (January Through September Only), by Industry

	Representation Elections [1/]				Decertification Elections			
	Total Elections	Won by Union	No Union Chosen	Percent Won by Union	Total Elections	Won by Union	Union Decertified	Percent Won by Union
Manufacturing	837	390	447	46.6%	179	52	127	29.1%
Transportation, Communication, and Utilities	283	142	141	50.2	55	10	45	18.2
Communications Only	44	23	21	52.3	26	3	23	11.5
Wholesale	130	54	76	41.5	47	10	37	21.2
Retail	171	74	97	43.3	94	23	71	24.4
Services	486	264	222	54.3	98	26	72	26.5
Health Care Services Only	201	113	88	56.2	37	13	24	35.1
Finance, Insurance, and Real Estate	37	26	11	70.3	7	1	6	14.3
Construction	169	91	78	53.9	14	3	11	21.4
Mining	15	6	9	40.0	3	1	2	33.3

1/ Does not include decertification elections

Source: Raymond F. Mickus & Associates, Inc.

TABLE 10

National Labor Relations Board elections and outcomes in nongovernmental hospitals, by selected hospital and area characteristics: August 1974-December 1979 and January 1980-May 1985[1]

Selected characteristic	Number of hospitals with elections		Percent of hospitals with elections[2]		Number of elections		Number of union victories		Union victories as a percent of elections	
	1974-79	1980-85	1974-79	1980-85	1974-79	1980-85	1974-79	1980-85	1974-79	1980-85
All hospitals	556	537	16.2	12.8	1,025	834	498	397	48.6	47.6
Census division										
New England	58	59	24.9	25.2	106	92	61	45	57.6	48.9
Middle Atlantic	156	172	31.4	30.5	310	303	163	149	52.6	49.2
South Atlantic	33	32	7.5	5.1	55	50	23	19	41.8	38.0
East North Central	121	93	20.1	13.0	221	131	91	51	41.2	38.9
East South Central	17	11	8.2	3.7	23	21	13	9	56.5	42.9
West North Central	27	26	6.7	5.4	51	33	25	16	49.0	48.5
West South Central	13	4	3.4	0.1	18	6	4	3	22.2	50.0
Mountain	25	22	12.5	9.2	39	32	20	14	51.3	43.8
Pacific	106	109	23.5	20.3	202	152	98	80	48.5	52.6
Puerto Rico[3]	—	9	—	20.0	—	14	—	11	—	78.6
Ownership										
Nonprofit-religious	115	83	17.7	10.6	176	135	64	63	36.4	46.6
Nonprofit-non-religious	395	403	17.6	15.3	756	623	381	311	50.4	49.9
For-profit	46	51	8.6	6.4	93	76	53	23	57.0	30.3
Bed size										
Less than 100	118	112	7.8	7.7	204	159	108	84	52.9	52.8
100-249	207	202	18.5	16.8	387	333	186	159	48.1	47.7
250-399	121	117	25.8	23.0	198	181	86	76	43.4	42.0
More than 400	110	106	33.0	20.4	236	161	118	78	50.0	48.4
Right-to-work										
No	509	504	21.4	19.0	950	785	474	378	49.9	48.2
Yes	47	33	4.6	2.2	75	49	24	19	32.0	38.8
Worker protection										
No	268	227	11.2	7.5	453	340	176	137	38.9	40.3
Yes	288	310	27.9	26.5	572	494	322	260	56.3	52.6

[1] Data for the period 1974-79 appear in Becker, et al. (1982), Table 4.

[2] Based on census of AHA registered hospitals 1974 and 1984, respectively.

[3] Due to research design, Puerto Rico was not included in the 1974-79 study.

SOURCE: National Labor Relations Board: *Monthly Election Reports* for two 65-month periods, August 1974-December 1979 and January 1980-May 1985.

> "this exists partially because administrators use stall tactics and delay union attempts to form bargaining units in hopes that workers will lose interest in unionization during the lengthy hearing and litigation process. Therefore, unions are being more selective about where a campaign will be initiated." (Gerry Shea, interpersonal communication, 1989).

As of 1990 hospital election activity has remained at a standstill while elections in long-term care facilities have steadily increased. This is particularly because of the recent long-term care exposure and regulatory pressure.

Future legislative factors affecting the industry. A major event affecting union election activity was introduced to legislation in 1987 called the St. Francis II (still in appellate court). The National Labor Relations Board is proposing an "appropriate number" of bargaining units. The rule would create six to eight bargaining units for hospitals with more than 100 beds and four units for hospitals with fewer beds. For the larger facilities, the NLRB would recognize these six bargaining units: physicians; registered nurses; other professionals; medical technicians; service, maintenance and clerical employees; and security guards. According to the NLRB, "this disparity limits disruption of hospital functions by

reducing initial organizing, jurisdictional disputes and sympathy strikes."

Currently, three categories of units exist; professionals, non-professionals; and guards, with doctors lumped into the first group. The NLRB bargaining unit rule was set to take effect in May of 1989 but a Federal Court barred the implementation until it decides whether the regulations violated congressional intent (Burda, 1989).

Another upcoming NLRB legal issue concerns the health care mergers, acquisitions, new subsidiaries or satellite facilities. Because of the competitive environment, improved delivery of care, reduced institutional care, increased technology, and wellness education, innovative health care administrators have sought to restructure their organization to enter new fields of service and increase profits. The NLRB may disregard the independent corporate status of two related entities. The successor employer must concern itself with its liability for unfair labor practices of the seller. A health care facility that merges with another may be obligated to honor existing

union contracts (Fries, 1986).

Chapter II

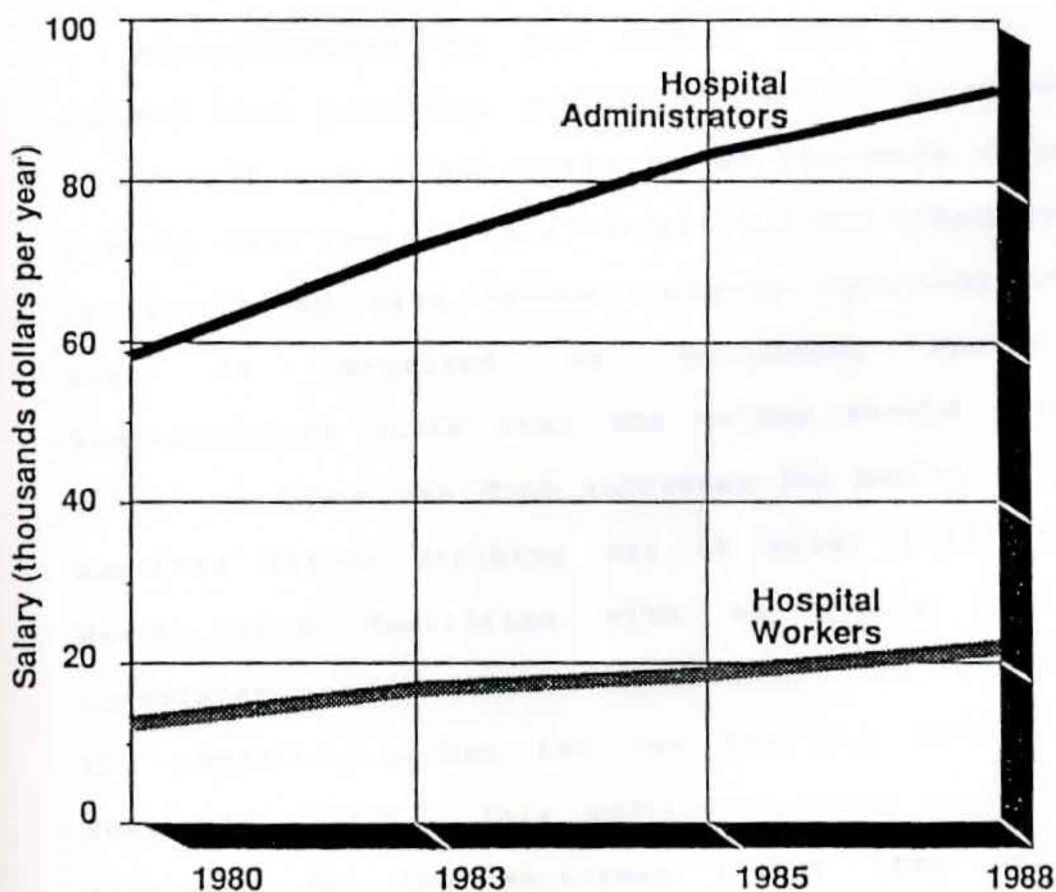
Union verses Management:

Responses Regarding the Health Care Crisis

Health care services/reimbursement. The mission of providing the highest quality of care by facilities to their recipients is the impetus of the largest debate in the health care industry. The union maintains that quality and care should not only apply to the patients of these facilities, but also to the employment policies and benefits of all the employees - not just management. For example; between 1980 and 1988 hospital administrators' salaries increased from approximately $58,000 to $92,000 annually while care-giver wages went from $12,000 to $22,000 annually for the same period (see Table 11). This type of budgetary biases further presents itself in the federal positions. Elected officials (Congress, etc.) pay nothing for full coverage health care while the indigent and elderly are recent targets of budget cuts for the same benefits (William Stodghill, President, Local 50 SEIU, April 1990).

According to the 1986 National Access Survey, 43

TABLE 11



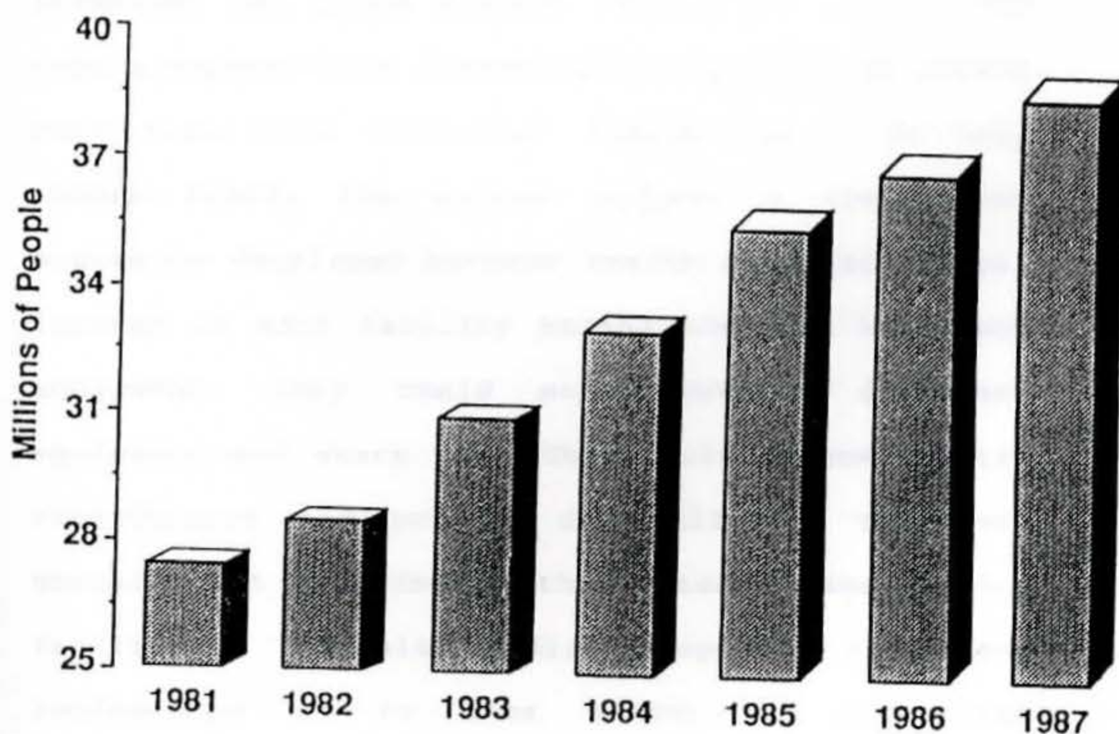
SOURCE: *Modern Healthcare (annual) Compensation Surveys, and BLS Supplement to Employment and Earnings, Nonsupevisory Worker Wages 1980-88.*

Service Employees International Union, AFL-CIO, CLC

million people had no regular source of health care. Another 15 million people did not seek health care because they could not pay for it or were denied services. The Census Bureau reported that in the same year (1986) 37.4 million Americans were uninsured (see Table 12). The irony of this situation is that 28.9 million of them were in the work force with 60% in the service-producing sector. How can providing health care to all be a priority with these statistics.

Administrators in the health care industry contend that providing quality of care is directed at several levels and needs to be evaluated on a case by case basis. Cost constraints and budgetary re-structuring have caused cutbacks resulting in what is perceived as management apathy. Administrators state that the unions should look closer at their own cost increases for health care services before striking out at other policies. Health care facilities with an active union translates into a 12-15% higher start run cost to the operating budget for the facility (Sloan & Steinwald, 1980). This additional money could be allocated for the employees rather than union

TABLE 12



SOURCE: *CPS, 1981-87.* ***Service Employees International Union, AFL-CIO, CLC***

pockets. Also, unionized employees experienced greater yearly increases in costs for health benefits than non-unionized employees. In 1987 expenses grew by 8.2% to an average of $2,364 per unionized employee where non-unionized employees costs increased only 7.9% or $1,904 per employee (Hoffman, 1988). This is a direct contradiction to the union's "what's best for the employee" attitude.

The reimbursement system has created a crisis in the health care industry. Rising insurance premiums, DRG price fixing, regulation, labor, and supply expense have dramatically impacted the health care facilities financial flexibility. To help absorb costs, the unions suggest a cooperative system be developed between health care facilities. Instead of each facility having the same high-tech equipment, they could each purchase different equipment and share it. This would reduce capital expenditures and put to use full-time equipment normally not demanded to that extent. Health care facilities recognize this proposal and have implemented it to some extent in some area hospitals. But competition has caused a duplicative, overbedded and maldistributed delivery

system controlled by physicians who are not about to relinquish control or be inconvenienced by a cooperative health care enterprise. Besides, this cost containment method does not adequately offset the expenditures to the extent that the unions claim in order to provide the benefits they want to negotiate. Facilities cannot contain costs as fast as they rise. HCFA announced that national spending for health care had more than doubled in eight years jumping from $248 billion in 1980 to $550 billion in 1988.

Labor organizations combat this issue by trying to instill that HCFA needs to review and re-evaluate their present reimbursement policies. The National Leadership Commission stated that the Medicare program alone could save $5.9 billion dollars over the next four years simply by changing physician practices. Eliminating unnecessary and inappropriate care has a potential savings of $84 billion dollars over fiscal year 1990-1993.

<u>Technology/evaluation and use</u>. Medicare is the single largest payer of health services in the United States (Hoffman, 1988). In an effort to control cost there has been a continuous decrease in

the services paid for by Medicare. The area of new medical technology is one where careful evaluation and monitoring of usage could offer budgetary savings. Presently the technological costs to the industry are out of balance. With so much earmarked for diagnostic equipment, the quality of working conditions, salary, and benefits for employees can deteriorate (William Stodghill, President, Local 50 SEIU, personal communication, 1990). However, management contends that labor cost still accounts for 60+% of total budget (Jerry Schwartz, National Health Care Corporation, personal communication, 1990).

Health care consumers have shown an increased awareness of health care quality, cost, and technology (Shepherd, 1988). This growing awareness of the methods and treatment available is producing a greater input by labor. The bargaining units see technology in its broadest sense. With greater demand should come more competition, price reductions, and widespread availability of this technology. According to Whitcomb, (1988), "Hospital administrators are dealing with government and third party payers who seem to be committed to

the concept that technology assessment information should be vigorously analyzed before decisions are made regarding coverage and payment for health care services, and that a cohesive technology assessment policy is needed for this purpose."

These concepts could limit a hospital's ability to finance both the procurement of new technology and the existing technology-related services. Administrators become caught in the middle between providing affordable technology and satisfying the physicians and regulators. This results in a conflict between health care administrators and the union regarding technological issues.

<u>NLRB proposal</u>. As the possible implementation of the NLRB ruling on the number of bargaining units for health care facilities draws near, conflict and tension are heightened as administrators are concerned about their organization's vulnerability to unionization as their counterpart, labor organizations, are preparing for battle. Union officials and hospital executives have been debating each other for months during hearings and appeals with a flood of testimonies and statistics.

Health care facilities oppose the NLRB proposals

in general and particularly the smaller bargaining units. Their issue is the proposal does not recognize the employment, financial, and patient needs of the facility. They contend it would create undue proliferation and result in territorial disputes among units with numerous and costly negotiation procedures. There would be more time spent at the bargaining table, additional loss in productivity and higher fees for negotiators (Holtast, 1987). Michael Anthony, Senior Vice-President for American Hospital Association in Chicago, complained that "too many bargaining units could result in more strikes, disrupted patient care and additional costs." Linda Kape from the Missouri Hospital Association further stated that such a plan will decrease productivity, increase expenses and result in less flexibility in making work assignments and providing cross training.

A result of organizing into small bargaining units would be that the unions would no longer need support from the doctors to organize the nurses into a bargaining unit. Organizers also would need fewer affirmative votes to represent workers (Hoffman, 1988).

Past situations, where two or more bargaining units were negotiated separately, have ultimately dissolved into a joint negotiation and contracts incorporated into one. This occurs because common interest of the employees becomes apparent. Consequently, the facilities are attempting to persuade the NLRB to keep the current case-by-case approach.

Union officials support the proposed rule. They contend that hospital strikes are rare and management wants no regulation because the case-by-case approach stalls union organizing (Davidson, 1988). According to information obtained by the AFL-CIO from the Federal Mediation and Conciliation Service, there are fewer strikes in health care institutions than in any other industry. In 1986 the figures were 4.4% for other industries and 1.5% for health care; the first 11 months of fiscal year 1987 all-industries' figure was 5.3% compared with 4.9% for health care. SEIU's data showed that work stoppages occurred in less than 1.4% of the 2,700 contracts negotiated. Unions say that the interest of the employee will be better represented if more bargaining units are permitted in health care facilities. Since smaller groups share

the same work interest, problems and conditions unique to them are more readily identifiable. Also, the new rules eliminate the lengthy hearings and appeals process used to determine the composition of bargaining units. Supporters believe that the varied employee groups need separate bargaining units to best represent them. Favoring the proposal are the AFL-CIO, American Nurses Association, and the Service Employees International Union (SEIU). Also in support is the American Medical Association that feels the creation of separate bargaining units is necessary to address the various needs of the profession.

Unions verses management; a change in strategies.

Assuming that conflicts between management and staff partially caused by technology, the reimbursement system and the potential NLRB ruling, labor organizations and administrative staff have devised various strategies to gain or regain employee support. The biggest lesson that unions have learned is that the traditional means of organizing must be modified. Unions are letting their members know that although they get their pay check from the health care industry, they are taxpayers and live in the

community. Members are realizing that when they put themselves in the role of the taxpayer they can take their message to the public (Verespij, 1987). This broadening of scope gives them a larger audience. These enlightened members are gaining community support through awareness campaigns aimed at educating consumers about technological issues, staffing shortages and governmental constraints. These tactics and strategies are instrumental to ensuring the survival of the health care providers.

The new battleground also includes exerting financial pressure. A new breed of union tacticians is turning its attention toward corporate America, with community support. The strategy is often devised by hired professionals. This staff keeps the pressure on several fronts, including law suits, public hearings, demonstrations, and appeals to federal and state legislators (Verespij, 1987). According to Susan Kelloc, a lawyer for the Kamber Group in Washington, "developing a corporate campaign that will impact the company's pocket book rather than public embarrassment works the best."

SEIU, representing the health care industry, is one of the most active in corporate campaigns.

Through these campaigns, unions are serving as a focal point for a coalition of issues that show what benefits the union offers the community. This has expanded the definition of a worker as a member of the community and has heightened the union's self-image while increasing the public's perception of unions (Verespij, 1987). Unions are aware that their strengths lie in their visibility, especially in the health care industry. Learning to capitalize on this image is a strong tool.

Another phase of the corporate campaign is the hiring of negotiators with appropriate educations. Professionals are linked with other skilled employees of similar backgrounds to identify the issues, concerns, and needs of the industry. Labor is also learning to deal with different cultures of the work force, so the organizer who comes to negotiate is well aware of the group being represented (Kelly & Bradford, 1988).

To combat this attack facility administrators have begun practicing "preventive management." Managers are conducting attitude surveys and developing formal programs for airing grievances and opening communications. They are scheduling group

meetings for information sharing and giving the perceived "management does not care" attitude a face lift. They are learning that giving employees most of what they want is cost free. Employees want better communication, more scheduling fexibility, a better understanding of how decisions that affect them are made and by whom, and better supervision (Richmond, 1987).

According to Marian Kling, an administrator for St. Andrew's Management Services, a popular technique of preventive management is the use of outside consulting firms to educate management and employees on union tactics. These firms specialize in teaching management how to achieve a positive work environment and satisfy the needs of both the employees and the administration. They also inform employees of the negative aspects of unionization such as limited opportunity for upward mobility due to "seniority only" promotions, and salary and bonus restrictions due to wage contracts (personal communication, Walter Hamstead, catholic Hospital Association, 1990).

To avoid union organizing, management is implementing regular contact with employees, effective communication, competitive benefits, and

sound management practices. These techniques help to improve morale, which brings less turnover, fewer absences, and better services (Hoffman, 1988).

Chapter III

Discussion

Current government regulations and reimbursement policies are constraining both unions and management from successfully achieving their goals of quality patient care and quality of life for the providers. The health care industry, government, and the American people have failed to prioritize the health care needs of the nation. This unique situation, compounded by rapid technology and longevity has prompted union activity in the health care industry and will require some serious compromising from both management and labor organizations especially at the bargaining table.

Lengthy negotiations or strikes are a financial drain on both the unions and health care facilities. Good faith management practices and good faith bargaining by labor can drastically reduce or eliminate many of these costs. William Stodghill, President of Local 50 in St. Louis, Missouri, states that the union is making every attempt to spend as little time as possible at the bargaining table. The key to cost control is knowing the workers' needs,

aspirations and corporate campaign organizing. Also, management is developing contingency plans to review staffing concerns, address strategic areas of operation, and help set priorities (Lohrmann, 1989). These plans are a survival process - never an anti-union tactic. They safeguard patient interests and fulfill operational and fiscal responsibilities.

Avoiding strikes should be paramount to both. Loss of productivity to management and loss of wages to workers, and the effect on patient care, can never be regained. Unions state they are pushing to coordinate bargaining and suggest contracts which have the least disrupting affect on patient care while achieving an equitable pact.

Management and the unions should consider both the substantive and the future relationship outcome of any negotiation. The relative importance of these two outcomes influence executives and labor representatives in deciding whether and how to negotiate (Savage & Blair, 1989). Both parties need to let these factors guide their decision process. Unfortunately, both parties typically do not consider how the negotiations will affect their relationship with the other in the long run. This blind spot is a

good reason for strategic negotiation practices. The prior relationship and the unfolding one have substantial bearing and will often determine the motivation to share or grab by the negotiators. While negotiating alternative proposals, both parties should be aware that a settlement which is not better than their best alternative to a negotiated agreement should be avoided (Fisher & Ury, 1981).

With any labor/management confrontation there is also the media event. This publicity may be positive or negative for either side. The important aspect from this line of action is that both the union and the facility will be sending a strong message to each other that a strike is viewed as a survival process. Identifying vulnerable areas and proposing actions which put patient interests first is paramount to both parties. Management and the unions have an operational and fiscal responsibility to the employees and the patients.

Negotiation is one way for unions and management to settle conflicts and accomplish new projects. By anticipating negotiation scenarios and selecting proper strategy both parties can enhance communication and achieve solutions.

Another area of compromise should be in the regulatory arena. The American College of Health Care Executives or the American Hospital Association are not in as strong a position to influence policy at the national level as labor organizations. Unions have more manpower, accessibility, time and financial support to lobby and attempt national health care reform. They are mobilizing to become a part of the legislative process. Labor organizations and health care administrators should coordinate efforts. Administrators can provide information in cost studies from the facilities viewpoint and unions from the labor side. This will bring to the legislators attention, in full view, the budgetary discrepancies they have implemented.

One example of such a budgetary contradiction exists in the State of Missouri. This state is rated in the top third of the nation for regulations/standards to receive licensure, yet is forty-eighth in providing funds to meet these standards (unidentified source, Division of Aging, 1990). The SEIU has already begun taking steps toward national reform. Having management as an ally can only intensify the power and bring about a

positive change in the government reimbursement policies beneficial to health care facilities.

Management and labor organizations need to meet on common ground. Both agree that because of government policy it is becoming more and more difficult to achieve and maintain quality patient care and motivating working conditions. What further indicates the need for a union/management integration is expressed in the following paragraph from the SEIU statement of principles which reflects opinions that have been expressed by both parties.

> "The health care industry has failed to prioritize and recognize the needs of the providers. Health care workers provide the most important of all services - those that sustain and nurture life. Our ability to provide these services is hampered - even threatened - by government policies that shift resources away from health and human services by large and powerful employers operating on a profit-making model of health care;" (SEIU statement of principles, 1990).

The 1980's have brought restructuring and cutbacks in health insurance and the market approach to medical cost containments. Administrators are forced to work in an atmosphere of budgetary contradictions, trying to provide quality of care while adhering to the cost constraints imposed by

regulations. Now more than ever the importance of reliable accounting information is essential to control cost and manage effectively.

The challenge is to make their operations more efficient and profitable. Trade-offs between quality and cost are difficult decisions regardless of who is making them. Obtaining accurate data and its evaluation is the critical difference between those facilities that maintain financial viability while providing quality patient/employee care and those that cannot.

The employee/human relations concerns already discussed in this paper are the result of inadequate government health care policies and the facilities neglect to practice creative and preventative management techniques. It is this writer's opinion that it is managements' responsibility to develop and maintain a working environment conducive to meeting employee needs and providing quality patient care. An environment which does not promote self-worth, upward mobility, and enthusiasm can breed discontent, apathy, and frustration in the employee. An atmosphere like this will "snowball" and bring about inadequate patient care. If management develops

practices which demonstrate a sincere commitment to treating employees fairly, this can result in good patient care and eliminate the need for union organization.

This paper would be somewhat incomplete without discussing the current nursing crisis. Industry experts contend that current labor strife is centering on the registered nurse profession for a number of reasons. First, the critical shortage of registered nurses is increasing. Starting from 1987 this shortage could range in numbers from 100,000 to 150,000. This translates into increased work loads for the existing staff. There are also widespread attempts by the industry to keep wages low (interpersonal communication, James Velghe, Management Services Association, 1989).

Disputing this is the American Nurses Association that contends the shortage exists only in specialty areas and that many nurses are leaving the high pressured departments for home health agencies, HMO's, insurance companies, and teaching. These positions offer similar pay and better benefits.

During an eight month period all union campaigns reviewed centered around nursing issues. For

example, two-tier wage scales under which new nurses start and remain at lower salary levels than those of current employees will become more prevalent in health care this year. Also, the limited supply of hospital-based nurses means those who work in hospitals have greatly increased work loads (Richmond, 1987). Consequently, if management cannot implement innovative and acceptable policies, these nursing issues could prompt union organizing.

At this time it seems appropriate to discuss in further detail some of the more controversial issues mentioned in this paper. While it is true that from 1980 to 1988 salaries for administrators increased from $58,000 to $92,000 and care givers wages went from $12,000 to $22,000, that is only a 58.6% increase for administrators versus an 83% increase for care givers. Further information should be obtained before passing judgment, such as increased average responsibility of the two groups over the study period. Also, salaries for care givers are lower as economic law states that skill level and supply dictate price. A St. Louis radio station relayed information regarding a national study concerning the language skills of high school

graduates in the 1950's versus the 1980's. The vocabulary of a 1950 high school student consisted of approximately 25,000 words while a 1980 high school student's vocabulary was approximately 10,000 words. Therefore, the more unskilled labor present in a job market equals lower wages for those laborers seeking employment.

In regard to the health care system and its reimbursement policies, it is important for the American public to recognize the relationship between use and who pays. Regardless of the number of dollars spent per facility for health care costs, the amount due per facility is proportionately divided among the purchases. Therefore, there is little incentive for limited spending or wellness/preventative programs. The "doc will fix it" attitude that prevails rather than individuals assuming personal responsibility to keep families healthy is affecting everyone and we all pay the price for high health insurance premiums.

As wealthy a nation as the United States claims to be it is not even rated in the top ten regarding the health status of its citizens. Unions and management need to coordinate efforts to educate the

American public on wellness/preventative methods of health care if a positive reform is to occur.

Until the general population understands that the lack of money is not the reason for an inadequate health care system we will continue to have difficulty making progress.

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