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pital workers has had little impact on the rate at which overall hospital per diem costs have been rising.[13] If this is the case, then a system of cost controls which effectively is geared to controlling labor input costs can have only a slight impact on reducing the rate at which total hospital costs are rising over the long run, since pressure for higher wages will probably not be contained by regulatory bodies.

Conclusions

With the growing use of regulatory efforts to contain hospital costs, and the recently proposed federal plan to establish a system of hospital cost regulation, the character of hospital bargaining will undoubtedly continue its shift from a bilateral to a multilateral situation. In both Maryland and New York, state cost-regulating agencies have made their presence felt in recent bargaining.

However, the long-run impact for controlling hospital costs by influencing bargaining outcomes is limited for several reasons. Prime among them is that labor costs may not be the engine of hospital cost inflation in the first place. Until the genesis of hospital cost inflation is better understood, policymakers should hesitate to suggest that wage control, through the implicit mechanisms of hospital cost control, is a solution to the troublesome problem of rising health-care costs.

[The End]

[13] Berry, p. 8, and Council on Wage and Price Stability, *The Rapid Rise of Hospital Costs* (Washington: 1977), p. 13.

A Discussion

By JEROME T. BARRETT

Federal Mediation and Conciliation Service*

I WAS DELIGHTED to be asked to comment on three distinguished research efforts on the health-care industry and also to have the opportunity to discuss with you our own research at the Federal Mediation and Conciliation Service (FMCS). Before commenting further, I would like to point out that the Office of Technical Services within the Federal Mediation and Conciliation Service, has a unique role: that is, one of attempting to bridge the gap between the industrial relations research efforts and the practitioners. This is not an easy task and is one that, I understand, the IRRA is grappling with now. I would hope that during the December 1977 IRRA meeting in New York City, a special session could be devoted to this problem. And now to the topic at hand.

FMCS has a very special interest in the health-care industry. Under the 1974 health-care amendments to the NLRA, which became effective two and one-half years ago, FMCS was assigned certain responsibilities. As a refresher, let me outline the important points of the amendments.

* Special thanks go to Lucretia Dewey Tanner, Senior Labor Economist, Office of Technical Services, FMCS, for the input into this paper and for efforts in the health-care study.

First, the amendments extended the National Labor Relations Act and the National Labor Relations Board (NLRB) procedures to nonprofit hospitals and other health facilities. As viewed by the framers of the legislation, the entire health-care industry required unique procedures to promote early bargaining and to deter strikes. This was to be accomplished by providing a 90-day notification to the other party of intent to reopen the contract, a 60-day notice to FMCS, a ten-day strike notice, and a Board of Inquiry procedure.

Under the law, the Director of FMCS, at his discretion, may appoint an impartial Board of Inquiry (BOI) to investigate the issues involved and to issue a written report on the findings of fact and recommendations for settling the dispute. Boards are to be established when a threatened or actual strike or lockout will substantially interrupt the delivery of health-care services. Between August 25, 1974, and March 1, 1977, a total of 129 Boards and special fact-finders were appointed by the Director.[1]

The 10-day strike notice provision requires a labor organization to give written notice to the institution and FMCS ten days prior to any strike, picketing, or other concerted refusal to work.[2] During the two and one-half year period, the agency has been aware of 151 stoppages, which represent about 4 percent of the Service's total health-care caseload, compared to strikes in 15 percent of all FMCS cases. I will discuss this in greater detail later.

Quickly following the passage of the Amendments, FMCS established a Health Care Industry Labor-Management Advisory Committee, which continues to exist. Its function is to advise the Service on its policies and procedures relating to the health-care industry and to suggest methods for improving collective bargaining. The Committee, composed of seven leading representatives of labor and seven of management within the industry, also serves as a communication forum in a nonbargaining atmosphere.[3] This approach, I might add, has worked exceedingly well in nonhealth situations at the plant level and in area-wide committees established by FMCS.

The amendments require mediation for the first time in any industry. Under the amendments, the process is termed "mandatory mediation" as compared to the Taft-Hartley's language calling for "proferring mediation." This total involvement of FMCS in the industry has required additional

[1] I am careful in making a distinction between BOI and special fact-finding. This difference is one created by the Service to differentiate procedures and funding. A BOI is fact-finding appointed under the Section 213 provisions. A fact-finding appointment, on the other hand, is one that is outside Section 213 and was developed as a result of early experience with the boards. It was found that, in too many cases, a board was appointed before the parties had had sufficient negotiations for recommendations to be meaningful. As developed by FMCS, if it appears that bargaining will be enhanced at a later time with the assistance of a fact-finder, the parties sign a stipulation that one may be appointed at a specified date prior to the expiration date. This procedure has been used infrequently, as has the BOI process. In about one-third of the 129 situations, a fact-finding has been named.

[2] The NLRB, and recently the courts, have been further defining what Section 8(g) means, particularly in construction cases in which picketing occurs not against the institution, but against a subcontractor. A U. S. Court of Appeals has recently held that these 10-day notices apply only to unions representing the facility. *NLRB v. International Brotherhood of Electrical Workers Local 388*, CA7, No. 75-2152, January 28, 1977.

[3] Proceedings of the Health Care Labor-Management Advisory Committee meeting are available from FMCS.

time and effort on the part of mediators and regional and national management teams. As a result of this complete immersion, we have now an ever greater need for reflection and analysis; hence our interest in research.

FMCS Research

I'd like to turn to the FMCS research effort. First, the study was undertaken as a result of the agency's research function and its access to much of the data needed to undertake a study. Let me give you a capsule version of the project that has been under way since December 1976.[4] The purpose of the FMCS study is to review the impact of the 1974 amendments to the NLRA on collective bargaining in the health-care industry. The major components of the study include a review of the legislative history of the amendments, starting from 1935 and the industry's inclusion, its subsequent exclusion in 1947, the NLRB's assertion of jurisdiction over for-profit institutions, and an analysis of the 1972–74 legislative period.

A second phase of the project will entail an analysis of FMCS data and BOI reports, including notices of bargaining intent, mediation efforts, strike activity, and general characteristics of the parties in the industry. Another portion of the study will be the assembling of perceptions of the persons selected as Boards of Inquiry, mediators, and follow-up with the parties on various aspects of the process. Other sections will review implications of the NLRB decisions, the third-party payor issue, changes in bargaining structure of unions and the industry, and changes in wage patterns. It is an ambitious undertaking and, we hope, will be completed by December 1977.

After this lengthy introduction, I'd like to turn my attention to the mission at hand and discuss the three papers as they were submitted.

Basically, my remarks can be fitted into five categories: (1) how the papers differ from the impressions FMCS has from the feedback received from the mediators and preliminary study findings; (2) how the FMCS data concur; (3) significant facts uncovered by the papers; (4) applicability to the practitioners and, (5), some statement on methodology.

Review of Papers

Let me start by commenting on Juris's paper. Frankly, I'm happy to see competition with the Bureau of Labor Statistics. I think Professor Juris and the American Hospital Association are to be commended for establishing the most comprehensive data system on contract provisions in the industry. We are making no such attempt in our study.

I was particularly struck by the similarities between the hospital and other industry provisions provided by the BNA analysis. For some reason, people in this industry keep telling us that the health-care industry is entirely unique, yet the comparisons in contract provisions that Juris provides seem to indicate that the same basic employment conditions exist.

It is interesting to note that one of the findings corresponds with our early efforts, reported in the July 1976 issue of the LABOR LAW JOURNAL,[5] that is, hospital contracts are of a

[4] Funds for this study have been made available by the Labor-Management Services Administration, U. S. Department of Labor.

[5] A discussion of the first 12 months under the amendment. See James F. Scearce and Lucretia Dewey Tanner, "Health Care Bargaining: The FMCS Experience," LABOR LAW JOURNAL (July 1976), pp. 387–98.

shorter duration. Juris has found that only 25 percent of health-care contracts are for a three-year or longer period, exceedingly close to the 20 percent we have previously reported. FMCS data also include nonhospital institutions.

While we agree that this may be due to the absence of COLA provisions, we would caution that there may be regional variations. For example, on the East Coast, the League and District 1199 have a history of two-year contracts, while on the West Coast, three-year contracts are common. I'm sure this could be quickly verified by Professor Juris's computer.

I tend to disagree with the suggestion that longer contracts come as a maturing of the industry bargaining develops. With the uncertainty of federal cost controls or with local rate review commissions playing a greater role, it is possible that the parties may become less reluctant to enter into long-term agreements, especially without reopeners.

Clauses normally found providing for job security during economic downturns were not evident in hospital agreements, a major departure from the all-industry review. This may be explained by the fact that employment in this industry has been expanding and until now job security has not concerned employees. I would agree with Juris that this situation is bound to change as cost-cutting becomes necessary.

I might suggest that in addition to the comparison with all-industry contracts as reported by BNA, for which I understand there is no sampling method of any kind, I would also compare the hospital contracts with those surveyed by BLS. Although their sample includes only the major agreements, I would feel more comfortable with both comparisons shown. I would also suggest expanding the survey to include nursing homes and other health-care facilities. Comparisons between and among the various institutions would be a major contribution.

While I eagerly await the promised series of articles showing the provisions in detail, as scheduled to appear in the next several issues of *Hospitals,* I would also hope that complete information will be accessible to all levels of practitioners, including unions.

Turning to the second paper, "Union Effects on Hospital Administration: Preliminary Results from a Three-State Study," I'd like to concur with Professor Miller's observation that "very little research has been undertaken." In our own review, we have found that, for some reason, labor relations in the health-care industry has been overlooked by researchers. This is changing, and the 1974 amendments have provided an impetus to new and in-depth efforts.

Contrary Findings

One portion of the findings of Miller and his colleagues struck me as completely contrary to what the rest of the country has experienced. According to their findings, "In Wisconsin and Minnesota, the 1974 NLRA amendments have not markedly affected the level of unionization. . . . In Illinois, by contrast, there has been a good deal of union activity but very little union success." While we have not studied organizing activity in great detail, aggregate data from the NLRB's annual reports indicate that the number of elections and particularly the number of people involved in these elections jumped markedly from the pre-1974 level.

Joseph Rosmann, writing the AHA Journal *Hospitals*,[6] reported on the first year's organizing activity, and noted the increased number of elections. Martin W. Cooper, writing in UHA *Reporter*, Summer 1976,[7] showed that between September 1974 and August 1975, states with the greatest organizing activity included Illinois and Minnesota. FMCS information indicates that about 27 percent of our caseload in health care are negotiations for initial agreements, compared to 9 per cent of all cases. The comparatively high level of union organizing activity contrasted with the delays were confirmed and documented in the Oversight Hearings of the National Labor Relations Act held early last year.[8]

I'd like to move on and comment about the strike activity or lack of it. As noted in the Miller paper, "There has been almost a total lack of strike activity among unions in the three-state area once they have become established in hospitals." This lack of strike activity is not isolated to these three states; rather we have found this to be true throughout the country. We quote a 4 percent strike rate in the health-care industry versus about 15 per cent for all FMCS cases.

Miller suggests this may be due to the legal environment that had been created. I would offer other reasons as well. We at FMCS like to think it is due to diligent and effective mediation efforts, but in all honesty, as Leon Davis, president of District 1199, stated during the December 6 Health Care Labor-Management Advisory Committee meeting, his union has a no-strike policy. He also warned, however, that this policy is being reversed.

I think the unions in this industry are fully aware of the responsibility they and their members have and generally view the strike with great hesitancy. People choosing health-care occupations are frequently altruistic, and I'm sure the Florence Nightingale syndrome has not completely disappeared. Another reason may be that the strike in this industry is not an effective weapon. Health-care institutions have shown that accommodations are made to withstand work stoppages.

I find it extremely interesting that the grievance procedure and arbitration tend not to be used. Perhaps the parties have found a secret and would like to share it with us. Seriously, I would hope that the Miller study does go into the causes of this situation in greater depth. While a high rate of grievances and arbitration cases frequently triggers a warning signal that labor-management relations may be in trouble, the opposite may be just as true.

Recognizing that it is extremely difficult to summarize an extensive study into a few short pages, I feel the discussion of the union effects on wages and fringe benefits could be expanded. How, for instance, do we get to the 5 percent that unions raise relative wages? Additional questions might also be asked: Were there occupational differences? Geographic variations?

My comment about Juris's findings that job security has not been a factor in this industry applies to those provisions cited by Miller as well.

[6] December 1976 issue.

[7] *United Hospital Association Reporter*, vol. 14 (Summer 1976).

[8] *Oversight Hearings on the National Labor Relations Act*, Hearings before the Subcommittee on Labor-Management Relations of the Committee on Education and Labor, House of Representatives, 94th Cong., 2d Sess. Hearings were held between February and May 1976.

Both employees and their union representatives view health care as an expanding industry. While preliminary FMCS findings correspond with those presented by Miller indicating that patient care and related clauses are not specifically major issues, we have found that, in BOI hearings, these topics are frequently raised and discussed during bargaining, particularly among units of nurses.

Cost-Control Impact

Schramm's basic thesis is one that I can heartily agree with: that a cost-control mechanism geared to controlling labor input costs can have only a slight impact on reducing inflation in the health-care industry.

Collective bargaining increases can be closely scrutinized by state rate-review commissions and easily controlled. The real problem lies in the system of health-care delivery itself, including the overlapping services offered and the new sophisticated machinery each facility feels it needs. These are the costs that will be and are less controllable.

While labor costs in the industry remain substantial, they have actually declined, according to AHA figures. In 1972, payroll expenses for all hospitals represented 59.8 percnt of total expenses, compared to 55.7 percent in 1976.

According to a report issued recently by the Council on Wage and Price Stability, labor costs accounted for a declining fraction of total costs per patient day: 62 per cent in 1955 and 53 percent in 1975. The report attributes cost explosion to other factors.[9]

The experiences of New York and Maryland State Review Commissions, as well as the other nine states with such functions, should be studied in depth, with particular emphasis on policies and their impact on bargaining. Similarities or differences in the forms of union responses and patterns of development in these 11 states should be made part of this study or included in any subsequent undertaking. These findings would obviously have significance in any national plan, as pointed out by Dr. Schramm.

In our own study and review of the issues, the role of the third-party payor and the ability-to-pay question is raised repeatedly and is especially critical in New York State. We hope to focus on this subject in some detail.

Recently, I have been impressed by the number of experts in the labor relations field who have noted the increasing shift from a bilateral to multilateral bargaining model. At a recent IRRA Washington Chapter meeting, Sam Zagoria, Director of the Labor-Management Relations Service of the National League of Cities, noted this increasing consumer (meaning taxpayer) involvement in public-sector collective bargaining.

Speaking to the same Chapter a month earlier, Wayne Horvitz, who heads the Retail Food Labor-Management Committee, suggested that the public, at some near future date, may become involved in retail food negotiations. Other researchers have noted this as well, notably McLennan and Moskow and Kochan, as mentioned by Schramm, and have advanced the model of multilateral determinants. Based on just the two cases presented in New York City and Baltimore, all measures for multilateral bargaining seem to be met.

[9] "The Rapid Rise of Hosptial Costs," prepared by Martin Feldstein for the Council on Wage and Price Stability.

It is becoming more evident in the health-care sector that the public represented by government agencies are having greater inputs into bargaining. As an outgrowth of this development, new bargaining structures may emerge and the development of area-wide bargaining and greater cooperation, both among institutions and the various unions, may take place.

If Schramm continues his research, I would hope that the impact on the bargaining structure itself is developed in the traditional Dunlop model and is not limited to the outcome of bargaining terms.

Concluding Remarks

As has been so eloquently stated, the health-care industry has a tremendous impact on the national economy and the individual consumer. While it appears that bargaining in this industry results in contracts not unlike those found in other industries, except on job-security issues, it also appears that bargaining will be increasingly influenced by government.

It is important that policy-makers understand that, while it may be easier to control wage costs, an uneven application of controls could result in noncooperation and may lead to labor strife. We don't need that much more business. Hopefully, the researchers and practitioners can communicate this message to those formulating guidelines in order to avoid future problems. **[The End]**