Health Care as a Fringe Benefit in Labor Contracts

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WHEN the Wagner Act became effective in 1935, management and labor were charged, by statute, with the obligation to "bargain collectively . . . with respect to wages, hours, and other terms and conditions of employment." After exhausting all manner of legal challenges relating to the constitutionality and application of the act, employers—many of them reluctantly—accepted the obligation to bargain. Most assumed, however, that the scope of bargaining was limited to "wages, hours," and such controversial items as seniority, union shop, and "on the job conditions," as distinguished from the general area of "employee welfare."

So-called welfare items—such as life insurance, sick leave, and pension plans—were considered management prerogatives. Such benefits, if provided, were bestowed unilaterally to insure employee loyalty and were not subject to joint bargaining.

However, during the period of wartime wage and price controls, when more or less rigid formulas were applied to wage movement by the War Labor Board, pressures developed to eliminate employee payments into existing "contributory plans" and to expand negotiated benefits to include a variety of welfare items.

Union representatives and others argued that the phrase "other terms and conditions of employment" as used in the act was broad enough to encompass such novelties as hospital and medical care not only for workers, but also their families, as well as life insurance and pensions. Organized management reacted by rejecting this interpretation, and their negotiators were instructed to refuse to extend bargaining to include such subjects.

However, there was some lingering doubt about the interpretation that the National Labor Relations Board and the courts might place on the statutory phrase. Consequently, management interests made an effort to secure an amendment to the Wagner Act to limit the bargaining obligation to "conditions of work," rather than to "conditions of employment."

During the congressional hearings relating to the Taft-Hartley amendments, it was argued that Congress had not intended to include welfare items in the obligation to bargain but that in order to make this intent evident the act should be clarified. Congress did not accept the proposed amendment.

By 1948 the courts and the NLRB had concluded that the "legislative history" of the act not only negated any intent on the part of Congress to limit bargaining, but failure to pass the amendment demonstrated an opposite intent.

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Consequently, union and management negotiators became involved in a broad new field of bargaining for which, in my opinion, they were unprepared.

Early Bargaining Experience

A significant fact was that the unions had no idea what kind of protection could be obtained or for what price. An equally significant fact was that management had no idea what kind of protection might be available at any price.

Bargaining for welfare benefits in those days was pragmatic. Management in one of the early cases on the west coast decided to grant something at the lowest possible cost to avoid a strike. The union agreed to accept a modest payment in order to secure a breakthrough in negotiations. The parties agreed to a 2½-cent hourly contribution for welfare purposes. One major company refused to accept the result, preferring to pay 5 cents per hour more in wages to avoid acceptance of welfare as a part of collective bargaining. Having reached an agreement the parties for the first time undertook to find out what could be bought for 2½ cents per hour.

They turned first to major insurance companies and were told by these companies that experience tables which could be used in establishing premium rates for coverage in this field did not exist. It also was suggested that, even if experience were available, the insurance fraternity took a dim view of getting into this kind of underwriting.

After this denial of interest by national companies, one west coast-based insurer offered to write a contract that would provide 2½ cents' worth of protection. The carrier stated that of necessity it would be unable to guarantee either the benefits or the premium for more than 1 year. The employers and the union stipulated in their labor contract that if benefits could not be maintained, they would be cut back, rather than require any additional payment to meet higher costs. This initial experience was followed by many which were similar, except that the price to the employer was higher.

One of the most interesting developments of this early period of bargaining to establish health and welfare funds was the adoption of the $8.65 formula. Since no one knew or bothered to find out what kinds of protection were most desirable, or how best they could be supplied, or at what cost, bargaining proceeded on the basis of a cents-per-hour employer payment. And what formula was simpler than 5 cents per hour times 173 hours per month (4⅓ times 40 hours per week) to arrive at the magic figure of $8.65?

Only after establishment of these funds was negotiated and the volume of dollars available mounted did insurance companies and other organizations begin to compete to provide a schedule of benefits. It was not too long before the so-called old-line insurance carriers were seeking this business.

During the years when these $8.65 plans were adopted, management believed that the bargained price was the limit of its commitment. The theory was that workers would accept the lesser benefits that could be purchased at the original price if the benefits being purchased became too costly. It was unlikely that this reasoning would withstand the pressure of collective bargaining.

Management soon realized that as the costs of benefits mounted, the benefits would have to be maintained at whatever cost, rather than readjusted downward to fit the originally negotiated rate of contribution. To add to the problem, more and more unions wanted more and more desirable benefits to add to the package of protection, even as costs mounted.

Current Problems and Proposed Solutions

Without attempting to place the responsibility for allowing 20 years of the kind of bargaining which brought about the existing state of affairs, one can easily perceive a number of results.

1. Employers complain that benefits originally agreed to have become increasingly expensive and that increased costs are passed on automatically or through bargaining pressure to management.

2. Unions complain that new benefits are difficult to negotiate because the higher costs for existing services are charged by management against any package settlement in collective bargaining.

3. Both parties complain that they have become collection and disbursing agencies for hospital and medical services, without any control over the quality or organization of such services.

Mounting dissatisfaction within union ranks has impelled representatives of several international unions to meet to consider and plan a common program for future action. During a panel discussion before the 1966 Group Health Institute, Harry Polland, a San Francisco economist who advises many unions, urged the following goals (*1*).

"First," he said, "labor unions must be convinced to change their practices at the bargaining table and begin to plan for medical care rather than provide money for health plans. It will be necessary for experts in the health field to work with labor in the local community in order to develop specific programs. Ways and means must be found to include bona fide medical technicians as advisers to unions.

"Secondly, labor unions must be convinced to pool their resources and become involved in multi-union community programs not only in terms of their own programs, but to create a more rational organization of medical care services in the community.

"Third, labor must be urged to become interested in promoting legislation which will improve the quality and the availability of medical services. This is particularly important on the State and local level.

"Fourth, labor should consider appropriating or negotiating money for research to determine what their health programs are or are not achieving. Unions must take account not only of the kinds, duration, and amounts of welfare benefits, but also the organization of the services and the quality of the care.

"Fifth, concrete proposals for group practice should be developed in which existing facilities can be utilized and made available on the basis of flat monthly contributions. Community, county, and medical school hospitals and related facilities should be utilized in promoting hospital-based group practices.

"Whatever measures are taken to improve medical services, it is clear that communication between labor officials, representatives of the health services, doctors, government officials, legislators, educators, researchers, medical technicians, and others interested in comprehensive medical care must be intensified if constructive action is to be taken."

Need for Wider Cooperation

As a management representative, I agree heartily with everything Polland said. In identifying myself with his views, however, I would read "management" in each paragraph wherein he refers to "labor unions" or even better, I would relate his recommendations to "labor unions and management jointly."

Polland referred also to the fragmentation of health programs resulting from 125,000 bargaining contracts negotiated each year with 68,837 local unions affiliated with 181 national or international unions. I have no comparable figures relating to the number of employers involved in such bargaining, but I can assure you that more than 68,837 are affected by the 125,000 agreements. As an indication of the kind of fragmentation that can occur in a single industry dealing with a number of unions, I can cite the experience of the Pacific Maritime Association in its relationships with eight or more maritime unions.

During 1965 PMA employer members paid more than $11 million in contributions to eight welfare funds jointly administered by the bargaining parties, as well as additional sums to welfare plans of other nonmaritime unions. Some plans are insured, some provide for employee choice of insurance or group practice service, and some provide joint administration of payment of cash benefits without any insurance or group practice involvement. Benefits vary from plan to plan, as do costs for the same or substantially the same benefits.

The very structure of the trade union movement and the nature of collective bargaining have tended to produce mixed results in the health and welfare field. In addition other factors tend to produce fragmentation as well as deterrents to the sound growth of prepayment plans, especially those involving group practice.

Not only is the structure of the trade union movement fragmented, but interunion rivalries and competitive comparisons relating to the composition of welfare plans have caused de-

liberate diversity of coverage and benefits. Many unions have sought exotic and unproved or uneconomic benefits merely to be able to claim that they secured something different or better than some other union.

However, if the structure of the trade union movement is fragmented, what about the structure of management in the field of collective bargaining? When some in organized business claim to speak for management, their voices are often raised to demand elimination of national bargaining, industrywide bargaining, or even local association bargaining. The ideal situation, according to some, would be to limit all collective bargaining to a plant-by-plant basis. Although efforts to establish such a bargaining structure by law have failed, the philosophy is still widely accepted in some areas.

I advocate industry and association bargaining on the broadest practical scale because I believe it provides for stability and for greater social and economic justice. However, even if one disputes these high-sounding possible results, such bargaining provides a selfish protection to management. This is accomplished by minimizing the whipsaw effects of individual contracts made by rival unions and competing employers. Certainly, in negotiated group health plans, uniformity and sound value may be encouraged by broadening the base for bargaining rather than by reducing the base to the smallest possible segment.

Organized Resistance

Some portions of management present other barriers to pooling interests to create community health programs and more rational organization of medical care services in the community. Three barriers have been most apparent.

1. A carryover of resistance to accepting welfare items as a subject for collective bargaining is prevalent despite the almost universal inclusion of such items in existing labor-management agreements.

2. A mixed reaction relates such fringe benefits to the development of a welfare state. The reaction is mixed because some employers granted benefits initially in the hope of combating broader social benefits by legislation; others feel that they should be relieved of the burden by having the total problem taken over by Government.

3. Community prepayment plans, and especially those involving group practice, are suspected to be a form of socialized medicine.

In recent years, PMA has had several experiences which illustrate generalized as well as specialized management and professional resistance. I will cite only one that has to do with the inauguration of a pilot plan for providing certain types of dental care for children of longshoremen on the Pacific coast.

When the International Longshoremen's and Warehousemen's Union proposed that certain moneys accumulated in the PMA–ILWU welfare fund be spent to attempt such a program for 1 year, many management eyebrows were raised. To PMA negotiators, it seemed appropriate to contact the California Dental Association to determine the views of organized dentistry about the value as well as feasibility of such a plan.

Our initial inquiry elicited a completely negative evaluation. Not only was there no experience on which to base an estimate of the costs of such a program, but it was suggested that the dental profession would not welcome a prepayment plan or any tampering with the dentist-patient relationship.

Our next step was to ask the ILWU where they got the idea and why they thought it might work, particularly in view of the objections raised by the dental association. The union responded by giving us copies of a monograph published by the California Dental Association, written by one of its former presidents, outlining such a program, regretting that no pilot plan had been attempted, and expressing the hope that some organization would undertake to try it. We undertook it. I have the impression that despite earlier doubts and misgivings, the plan—which has been continued over several years—is now hailed by the profession as desirable, and dentists point to it with pride.

A New Approach

I do not mean to criticize management's interests; for 30 years I have represented management. Rather, I am suggesting that management is spending millions of dollars for

various welfare programs without, in some instances, realizing a full dollar's value in services either for industry or the employees. Just as unions are becoming interested in improving the quality and organization of these services, I think management should do the same—even if it means setting aside some overriding prejudices—in order to arrive at a value judgment in keeping with good management practices.

How can this be accomplished? There are many ways, but the basic problem, it seems to me, inevitably entails the fragmentation of both union and management ranks in the area of management costs.

Certainly it was to be expected in the early days of bargaining in this field that both craft and industrial unions would strive to outdo each other in securing the greatest benefits possible for their members. It also is readily apparent that both parties would focus their attention on the cents per hour the employer would pay into such funds. Out of such things has grown a tendency—on both sides perhaps—to build edifices or memorials as physical evidence of what they have achieved or to gain a competitive advantage.

Despite the shortcomings and shortsightedness on both sides, there is no doubt that the thousands of plans negotiated each year have resulted in materially enhancing the physical well-being of all persons directly or indirectly involved. Yet I hope that in the future there will be a far different and, what I believe to be, far more rational approach to this issue.

By this, I, as a representative of management, do not mean to imply that we should cease to bargain in this area. To the contrary, I believe management should bargain harder than ever to maintain a sensible cost for fringe benefits. Management negotiators should bend every effort to resist exotic, meaningless benefits and should invariably approach the bargaining table recognizing that these costs are as real as wages but much harder to control. Therefore I suggest that management continue to bargain hard and intelligently on health and welfare plans.

More important is management's future tremendous responsibility relating to the broadness of the base of negotiated plans and for careful attention to their joint administration. It can be assumed that the cost of identical benefits can vary widely depending on the group covered. A small group of workers in an industry that is not expanding can have a constantly increasing cost as the age level of the group goes up.

Though this is not considered truly a welfare item, PMA recently had pension negotiations with a union representing approximately 150 workers in the maritime industry. The work they perform is not physically arduous; actually, it usually attracts men age 50 or over. The cost of purchasing pensions at age 65 for this group will be considerably higher for each $10 of retirement income than it would be for a group with an average age of 35. The frequency and severity of illnesses in a group age 50 or over will also drastically increase welfare costs of these men if they are insured as a separate unit.

Recognizing that such groups appear all over the nation, representatives of management—responsible to stockholders for the most efficient use of the dollar—should lay aside their prejudices and discard the idea of offering better benefits than their competitors in the labor market. They should endeavor now to consolidate their efforts to provide the best benefits possible at the lowest cost available.

This group effort would not only bring the greatest benefits to the recipients under such plans—which is what we all should be striving for in health care—but at the same time it would provide the benefits at a lower cost. In my view as a management representative this is not socialized medicine or a welfare state; it is the antithesis, namely, management in a capitalistic, free enterprise system fulfilling its community responsibility and at the same time operating its business more efficiently.

A second area where management must take a firmer, and perhaps new to many, position is in the administration of the multitudinous jointly trusteed plans. I have seen evidence in the industry in which I work—and I am sure it exists in others—that once the cost of a welfare plan has been negotiated, administration of the fund has been turned over to either an administrator hired by the joint trustees or to an outside agency. Too often the administrators

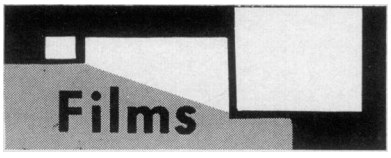
have not been professionals in this complex field, or the outside agency was not directly concerned with a cost-conscious administration of the negotiated fund. I believe that management now must take a more aggressive attitude in fulfilling its responsibility in welfare fund administration.

Conclusion

In the future both labor and management, after they have negotiated the price or the benefit and left the bargaining table, must work—not as adversaries but as partners—in research, study, and cooperative ventures to secure needed benefits at the lowest cost possible. This means lowering house flags—as we say in the maritime industry—or the union banner in a concerted effort to derive the greatest benefit in health care for the most people at the lowest price.

REFERENCE

(1) Proceedings of the meeting of the Group Health Institute, St. Louis, February 23–24, 1966. Group Health Association of America, Washington, D.C.



The 3rd Pollution. *Motion picture, 16 mm., color, sound, 23 minutes, 1966; order No. AM–1404. Produced by Stuart Finley, Incorporated, with technical advice from the U.S. Department of Health, Education, and Welfare, Public Health Service, and the American Public Works Association.*

AUDIENCE: General public, with particular emphasis on civic groups and high school and college students. Also of interest to local and State public health agencies and municipal officials.

SUMMARY: Demonstrates and explains how burning refuse contributes to air pollution and how dumping refuse contaminates water. Emphasizes that the collection and disposal of solid wastes is expensive and technically challenging. Municipalities are abandoning earlier haphazard methods and are switching to more sophisticated public works procedures. A brochure containing a program guide and a study guide is available and should be used when the film is shown to civic groups or used by educational institutions.

AVAILABLE: Free short-term loan from Public Health Service Audiovisual Facility, Atlanta, Ga. 30333, Attention: Distribution Unit. Purchase from Stuart Finley, Incorporated, 3428 Mansfield Road, Falls Church, Va. 22041.

Laboratory Design for Microbiological Safety. *Motion picture, 16 mm., color, sound, 35 minutes, 1966; order No. M–1091. Produced by the Public Health Service Audiovisual Facility for the Special Virus Leukemia Program, National Cancer Institute, National Institutes of Health.*

AUDIENCE: Architects, engineers, laboratory personnel, and scientific administrators.

SUMMARY: Approaches safety problems from an engineering standpoint in the design and construction of a microbiological laboratory and describes the primary and secondary barrier concept for the containment of micro-organisms. Describes the five functional areas of a typical microbiological laboratory—the clean area, laboratory research, small and large animal research, laboratory support, and engineering support. Preceding the description of each area, a flow diagram shows relationships of the various areas, followed by illustrations of devices and building features from laboratories currently in operation in the United States.

AVAILABLE: Free short-term loan from Public Health Service Audiovisual Facility, Atlanta, Ga. 30333, Attention: Distribution Unit. Purchase from DuArt Film Laboratories, Inc., 245 West 55th Street, New York, N.Y. 10019.

Enemy in Your House. *Motion picture, 16 mm., color, sound, 14 minutes, 1965; cleared for television; order No. M–911. Produced by the Public Health Service Audiovisual Facility for the National Communicable Disease Center, Atlanta, Ga.*

AUDIENCE: Health and health-related organizations, civic and fraternal groups, and the general public.

SUMMARY: Relates the story of a southern businessman who becomes infected with the virus of dengue while on a trip to the Caribbean. Later, a mosquito bites him and transfers the disease to others of the community. From this introduction, the film moves to the role of the local health department in eradicating the disease-transmitting mosquito by destroying breeding places. The success of such a source-reduction program depends on the cooperation of every household in the community. Cooperating with health department inspectors, cleaning roof gutters, and disposing of cans, tires, and other receptacles that hold water contribute to communitywide efforts to stamp out the yellow fever-dengue mosquito.

AVAILABLE: Free short-term loan from the Public Health Service Audiovisual Facility, Atlanta, Ga. 30333, Attention Distribution Unit; purchase from DuArt Film Laboratories, Inc., 245 West 55th Street, New York, N.Y. 10019.