TALKING POINTS

Unions and hospitals: the American case

NICK BOSANQUET

In American hospitals unions are adrift in a hostile environment. In a few places procedures and relationships are well established but where the unions are not recognised there is a great deal of fear. There is a vast gulf between the strong resistance to collective bargaining where it does not exist and the orderly relationships where it does. Hospitals without unions consider themselves fortunate. But in practice they have to maintain approaches similar to bargaining and there is always the possibility of conflict over recognition. The main effect of the absence of unions seems to be to strengthen the medical prerogative and the trends towards high-technology medicine and the large hospital.

There have been parallels in the development of industrial relations in Britain and the United States. In both countries anxiety has increased about the effect of strikes on patient care. This has led in the United States to special arrangements for mediation, while similar proposals have been made for the NHS without definite action. Both countries suffer from the problem of low pay among hospital workers and in both there has been only a patchy improvement in personnel management in hospitals. While Britain's health care system is not analogous to that in the United States the American case can help to put the NHS's problems into perspective. It shows how large organisations will develop similar systems of industrial relations whether or not they have unions. It also shows that conflict over unions often distracts attention from more important developments in health care—developments which create symptoms that are often blamed on unions. The absence of unions has perpetuated the illusion of managerial "freedom."

Legislation became more favourable to unions in American hospitals at the time that opinion was shifting against them. Before 1974 it had not been possible for unions to seek recognition in non-profit hospitals under the normal processes of the Taft-Hartley Act. One study showed that in 1961 only 221 hospitals in the whole country had contracts and half of these were in three states—California, Minnesota, and New York. President Nixon, in one of his last actions, signed into law an extension of the procedure for balloting about union recognition to the non-profit hospitals. There were also mediation provisions.

The 1974 Act was expected to lead to a large increase in recognition. There was some: the proportion of hospitals with at least one contract rose from 15% in 1970 to 24% in 1977 but much more had been expected. If the Act had come 10 years earlier the result might have been different. By 1974 American unions were facing much greater hostility from employers generally, so that overall the proportion of the labour force in trade unions has fallen from 30% in 1960 to less than 20% today. Hospital management also had reasons for opposing unions because of its worries about the control of costs. Concern about rising costs has already led to a network of state and federal regulations which limit hospitals' freedom of action. Administrators worry that this freedom might be further reduced by union recognition. They would have less freedom to compete for higher occupancy and for the new medical

technology which attracts doctors and through them patients.

As in Britain there is friction between unions and between them and the professional organisations representing nurses. The American Nurses Association entered collective bargaining early, in part to protect professional status. It is now uncertain how long its state associations can continue to bargain because of legal difficulties and because of competition from unions. The division between the unions has also been unhelpful. The two main ones are the Service Employees International Union (SEIU) and District 1199 of the National Union of Hospital and Health Care Employees. The last five years have seen growing frustration and a sense of missed opportunity.

Resistance to unions in Boston

Resistance to unions has been intense and successful in the Boston area. Health is an important "industry" in the Greater Boston area, employing 4.2% of the total labour force compared with 3% in the United States as a whole. There are only two areas of union recognition: one is in the municipal hospitals run by Boston City, which are a shrinking part of the total system; the other is the traditional, low-key activity among professional nursing staff. Outside Boston there is more organisation among the smaller community hospitals.

Where recognition exists relationships are peaceful and where it does not managements greatly fear its arrival, with strategies for avoiding it varying in guile. Some employers try to do so indirectly by fair and objective personnel policies and pay levels. This is the tactic used in one of the main Harvard Medical School teaching hospitals, which is moving into new premises. The changeover, affecting 5100 workers, has been negotiated without difficulty, in part because a "no detriment" guarantee was given. The hospital offers a pay and benefit package which appears to be well placed in the Boston area rankings, including such items as subscriptions to Blue Cross and Blue Shield, life insurance cover, long-term disability insurance, and fees for professional courses. Holiday allowances are considered to be good for the Boston area and start at two weeks for unskilled workers and four weeks for nurses.

The hospital has its own grievance procedure. This includes a grievance board to which the employer appoints one person and the personnel department appoints two. There is also provision for a final appeal to independent outside arbitrators though the employee has to bear the cost of this arbitration, which can be at least \$1000. There has been one (successful) appeal to outside arbitration so far and in that case a union paid as part of its organising effort—a part which has not yet borne fruit. There were 24 dismissals for cause in 1978. Supervisors have to carry out personnel policies which are roughly similar to the guidelines on disciplinary action recommended by Britain's Advisory, Conciliation, and Arbitration Service. Though there is no general obligation on an employer to prove that a dismissal is fair to any outside body, he may have to do so in some cases where there are complaints about discrimination or about unfair labour practices, such as dismissal for taking part in union organising.

Thus nowadays a large employer does have to take into account some possible outside scrutiny of dismissal decisions.

Department of Social Science and Humanities, The City University, London EC1V 0HB

NICK BOSANQUET, BA, MSC, lecturer in economics

The hospital also has safety committees with employee representation which are concerned with health and safety legislation. The hospitals' general strategy has been to avert recognition by maintaining the kind of personnel policies which are generally thought to be the more attractive parts of collective bargaining. Unions have made frequent attempts to organise but they have been unsuccessful. There seems to be little sense of solidarity: according to management, unions are judged by whether they can deliver the goods.

Only nursing staff are organised in this teaching hospital and they became so 10 years ago, mainly because of anxieties about professional status. Day-to-day matters are handled by local stewards, of whom there are eight for the current 400-bed hospital. Management was confident that it could hold off further increases in recognition in the future.

Another nearby Catholic hospital associated with a university medical school illustrates a rougher approach to avoiding recognition. In 1978 Local 880 of SEIU tried to organise workers in this hospital. The hospital responded by employing a firm of consultants, "Modern Management Methods" (MMM), a firm founded by three consultants called Mickus, Melnick, and McKeown. They claim to act as "marriage brokers between worker and boss." As Herbert G Melnick put it, "We are in the business of helping employers effectively communicate with employees, getting back to one-on-one communication." The unions, however, did not see their activities at this hospital as being quite so benign. After a bitterly fought election for staff representation in June 1978, in which the union was narrowly defeated, the union filed 38 complaints of unfair labour practices with the National Labor Relations Board. These included charges that three people had been dismissed unfairly. Management implicitly accepted that there was substance in some of these charges. Rather than face a court hearing it agreed to take back three of the workers, hold another election, and discharge the three Ms. The union now regrets that it agreed to another election so soon after the first as in the event the result was little changed. The main issues which had led to the organising drive in the first place were worry about staffing levels and about the length of vacations. At the time of the three Ms the hospital in fact improved some of these fringe benefits. It is difficult, however, to see how the union will be able to mount another organising drive in the near future.

Such battles are fought in the name of medical "freedom." In practice, this is freedom to be caught up in a process of competition between hospitals and is rarely more acute than in the Boston area. Hospitals compete for doctors, who in turn attract patients to fill beds and so assure the levels of occupancy which are needed for viability. To attract doctors they need to be able to invest in the latest technology, which is financed through bank borrowing. This requires a guaranteed cash flow, which in turn depends on occupancy. State and federal regulations attempt to damp down this competition but hospitals become expert in evading them. The main victims of this competition are the smaller community hospitals.

State of play in New York

More is known in Britain about industrial relations in New York's hospitals than in the rest of the United States. But they are not a good guide. The New York pattern is one of recognition over many years, of high levels of organisation, and of important effects on pay and on the handling of disputes. The power of the unions is now being challenged not by management but by the changed fortunes of the New York hospital system.

An industrial relations system covers unions, employers, and also third parties. The power of the union (mainly District 1199) within the New York system has forced change both on the employer and on the third parties. The employers have become much more organised, for by 1966 it was already clear that single employers were no match for the union. By 1968

they had formed themselves into the League of Voluntary Hospitals and were negotiating their first contract. The league now handles all dealings with the union apart from day-to-day processing of grievances. The main effect on third parties was to stimulate a high pace of activity rather than any new institutions. As the founder of the league puts it: "Strong governmental intervention" has been the "hallmark of labour relations in New York City." Concern for patients and worry about saving lives has brought intervention from a wide range of people such as mayors, governors, and state and federal mediators. Attitudes have changed: in the past political third parties tended to press for a speedy settlement but worry about rising costs has made administrators less willing to pass on the costs of settlements.

One obvious impact of trade unionism has been on pay levels. Workers in non-profit hospitals used to be some of the most poorly paid in New York. They now earn more than \$5 an hour, together with excellent fringe benefits. Management's moral position was weak for several years because it had to accept that levels of pay were indefensibly low. It now thinks that pay levels are reasonable and this has altered its attitude in collective bargaining. The union has been less successful in limiting managerial prerogative in the way that the work is organised and in manning levels, though management has conceded a prohibition on subcontracting. In the city hospitals management prerogative has been rather more eroded.

"Impossible to fire anybody"

On a day-to-day basis industrial relations in the non-profit hospitals are highly organised. Issues include promotional opportunities and disciplinary problems such as absenteeism, lateness, and refusal to do job assignments. The new system has proved a strain for many supervisors, who prefer older methods of approach. The complaint is often heard that it is "impossible to fire anybody." According to a management spokesman, the "hardest job" has been to convince supervisors that "there is a law of the shop." Industrial relations in New York has an added dimension—its closeness to the concerns of the civil rights movement. Complaints about discrimination figure more prominently than complaints through the normal grievance procedure.

New York City's population has declined in the last few years: the exact figure is disputed because nobody knows how many illegal immigrants have entered the city. As with inner London's fall in population, the decline is forcing adjustments in the hospital system—for example, many city hospitals have an occupancy rate as low as 60%. In the immediate future District 1199 will be relying less on its own strength than on the privileged position of its employers. Nor is the union likely to be more successful in wearing down managerial prerogative during this period of contraction than it was in the earlier period. The general outlook seems to be for relations to become more regular and routine over the next few years while the city hospitals suffer a series of crises.

There are similarities between industrial relations in the United States and in the NHS. These certainly exist at the political level, with the same problems about the effects of industrial unrest. But the main theme in the United States seems to me to be how the struggle over union recognition has helped to divert attention away from the key questions about the function of hospitals and the appropriate commitment by society to health care. Industrial relations, whether unions are present or absent, creates a world of drama and incident which makes it difficult to reach the important issues. Under the American system "freedom" is identified with a certain direction of growth for hospital care. Do we have the courage to face underlying differences about the meaning of freedom under the British system?

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