COLLECTIVE BARGAINING FOR MEDICAL CARE BENEFITS: A RECENT DEVELOPMENT IN THE U.S.A.

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1. GENERAL

Collective bargaining between trade unions and employers for health and welfare benefits has been perhaps the most striking recent development in the organization of medical service in the United States of America. The sudden burgeoning of plans resulting from such activity has out-distanced studies of them. However, it is known that by mid-1950 more than 7·6 million workers in practically every major trade union and a large number of their dependents were covered to a greater or less degree by such plans (Rowe, 1951; Brannon and Breher, 1951). A decade ago the number had been in the thousands.

Industrial medical care plans of many types and of diverse quality had an early origin in the United States, (Klem, McKiever, and Lear, 1950; Williams (1951). The Federal Marine Hospital Service (1789), which was created by a check-off from the wages of merchant seamen, followed the earlier English pattern of providing medical care for coal-heavers on the Thames. As this part of the western hemisphere was developed, mining and timber operations, railways, and other new industries starting in virgin soil found it necessary to provide some type of medical care through a wide variety of patterns to meet their diverse needs. Usually the unorganized workers had little or no voice in either the form or the pattern of these services, yet they paid the bills in one way or another.

But formal trade union collective bargaining for medical care benefits has been almost entirely a development of the last decade.

By 1949 they had become the primary issue on the collective bargaining agenda for many unions, particularly those in the basic industries (Becker, 1951).

The bitter strikes in the steel and coal industries in 1949 revolved largely around that issue. By 1953, practically all the members of large trade unions had at least partial indemnity for hospital and surgical expenses, all through some such agreement.

The currently developing labour-employer agreements on health and welfare benefits interact with

all other trends in the field of health and welfare, and can be expected to modify future governmental medical programmes. (This point is elaborated below.) The development has been so sudden that even the keen-sighted and intensive review, "American Medical Services", published in this Journal 5 years ago makes no mention of it (McKeown, 1948).

PREREQUISITES.—Some prerequisites for the development of the employer-employee medical care plans which we are discussing can be considered to have been:

- (1) The increase in trade union membership in the United States during the 1930s and '40s to some 15 million workers. This was helped by the provisions of the Wagner Labour Act of 1933, which fostered and protected collective bargaining.
- (2) Technological developments in the field of medical care. One such development was the use of group insurance in non-profit and commercial private medical care insurance. This had much to do with the creation and development of Blue Cross and Blue Shield, and of commercial hospital and surgical expense indemnity. Other factors were the growth of medical group practice, the increased understanding of the importance of preventive medicine, and the increased capabilities and the resulting public prestige of medicine because of scientific advances in therapy.
- (3) The failure of the Congress to enact a national health insurance programme, as proposed for more than a decade in successive Wagner-Murray-Dingell bills and their successors. These proposed National Health Acts represented labour's first choice of method for medical care payment.

CHRONOLOGY.—The specific catalyst was the "wage freeze" during World War II developed to help prevent inflation, and the concomitant National War Labour Board policy formulated in 1942 to approve as non-inflationary "Sickness Benefit" programmes not exceeding 5 per cent. of payroll.

The cost of such benefits could be deducted by corporations as business expenses, and this proved especially attractive in view of the high excess profits

taxes; corporations with substantial excess profits could provide health benefits as a tax-deductible item with little actual expense, since they would have had in any case to have paid much of it out in taxes. Most of the programmes were therefore totally, or primarily, employer-financed in lieu of wage increases (Becker, 1951).

By 1945, the Department of Labour, having searched the 12,000 union agreements in its files, found that about 600,000 workers were covered by health benefit plans established through collective bargaining (Peterson, Kassalow, and Nelson, 1945). The next year almost as many workers again, and all their dependents, were brought into coverage by an agreement creating the United Mine Workers of America Welfare and Retirement Fund. This important development is dealt with separately at some length below.

In 1949, the United Steelworkers and the United Automobile Workers, both of the C.I.O., and with membership of about two million, signed wage agreements which included nation-wide hospitalization and surgical service insurance based upon company and membership contributions.

Some American Federation of Labour unions, such as the International Ladies Garment Workers' Union, had earlier been in the forefront of the development, and other unaffiliated unions did not lag behind.

PATTERN.—"Group Insurance", covering a range of benefits developed as "package plans". Most workers were covered by pension, hospitalization, surgical indemnity, disability indemnity, and a modest life insurance allocation. These supplemented the Old Age and Survivor's Insurance payments under the Social Security Act. Some indication of the extent of these employer-employee plans is given in the Table.

It should be noted that in the Table the rows numbered 2, 3, and 6 deal with medical service. Hospitalization and surgical indemnity were commonly covered, but "comprehensive" medical care *i.e.* including also physician office and home calls, was only infrequently covered. The most common medical benefits were hospital and surgical (including obstetrical) coverage. Commercial insurance and Blue Cross were most commonly used, rather than the industries or unions providing their own services directly. Most of the sickness benefits and wage-loss indemnity start after a waiting period of one week in the event of illness, but from the first day in the event of an accident, the duration of both is commonly limited to 6 months. Invalidity indemnity (for disability of over 6 months) is not covered.

TABLE
HEALTH AND WELFARE UNDER COLLECTIVE
BARGAINING, 1950
Based on the plans of 140 unions with 4.3 million workers

Type of Benefit Provided	Plan Members Covered by each Benefit		
	Number (millions)	Per cent.	Employer-financed (Per cent.)
1. Life insurance or death benefit	4.2	96	67
2. Hospitalization	3.5	80	65
3. Surgical and/or Limited medical care*	3.1	72	72
4. Sickness wage-loss compensation	2.8	64	59
5. Accidental death and dismemberment	2.0	46	70
6. "Comprehensive" medical care†	0.4	10	no data

* "Limited medical care" ordinarily refers to in-hospital physician visits or consultations.

† Includes at least physician and surgeon service in the office, home, or hospital, and coverage of hospital bills.

In 1952 total disability payments were authorized by Federal law as a *public assistance* "Aid to the Disabled Worker", but were specifically rejected as a *social insurance* category. Thus the United States continues to follow the tradition of the Elizabethan Poor Law, rather than the recent British national insurance legislation.

SOURCES OF FINANCE AND DEPENDENTS' COVERAGE.—In the coverage reported in the Table, sole support by the employer accounted for 55 per cent. of the health and welfare plans, 37 per cent. being contributed to jointly or solely financed by the employee, and 9 per cent. undetermined. Dependents were automatically covered in only 20 per cent. of the agreements in this sample; in another 50 per cent. extra payment of premiums would include the dependents, but not ordinarily for the same full benefits as those received by the worker himself. The employer-financed plans were characteristic of the textile, apparel, leather, lumber, furniture, mining, printing, insurance, and finance industries. Employee contributory plans were dominant in the paper, petroleum, chemical, rubber, metal products, stone, and clay industries. The two patterns seem to be due primarily to differences in trade union strength. The findings of a nation-wide survey were published by the Research Council for Economic Security (1950).

COMPLEXITY.—The intricacy of the present pattern is revealed by an exhaustive survey made in 1950, in the San Francisco, California, Bay Area, where plans of the many American Federation of Labour (A.F. of L.) affiliates were studied (Weinerman, 1952). Over half of the 200,000 trade union members were covered by collective bargaining health and welfare

agreements. Among 71 local unions, 64 separate plans existed, with 24 different insurance carriers, administered from 45 different union, employer, insurance carrier, broker, or special fund offices. The Garage and Service Station Employees alone had five *separate* welfare funds. •

San Francisco is not unusual in this respect. It is only unusual in the fact that there the problem has been thoroughly studied. We in the U.S.A.—in our medical care plans—seem on the record to be trying to “muddle through”.

2. UNITED MINE WORKERS OF AMERICA WELFARE AND RETIREMENT FUND*

In May, 1946, the U.M.W. created its “Welfare and Retirement Fund”. Back of it was the philosophy of that union: the “human costs of production” must be borne by the industry which necessitates or creates them. It is perhaps the most unique and ambitious of the many labour-union sponsored employee benefit programmes.

The coal-miners felt keenly the need for such a fund for many reasons, the most persuasive one being the hazards of the occupation. Even to-day, one out of every seven coal-miners in the U.S.A. suffers a lost-time accident each year. Among the coal-miners currently employed, seven are killed each working day; each year two out of every thousand active coal-miners are killed at work.

Over the decades the question of *State* versus *Federal* responsibility for safety and other provisions for the miners has been debated. After the Federal Government took over nominal responsibility for operating all of the coal mines in 1944, Admiral Ben Moreell as Administrator called upon his medical colleague, Admiral Joel Boone, to make a survey of medical, health, sanitation, and living conditions among the 400,000 workers engaged in this vital industry.

The now well-known report which followed an exhaustive governmental survey (Boone, 1947), helped to spotlight the appallingly bad medical and hospital services in the coal-mining “patches” (communities). It also described the miserable environmental sanitation, housing, and recreation, and the lack of public health services. The report helped to document the widely-held opinion that conditions would have to change for the better if the workers in this industry were to survive and produce the needed commodity.

The Mine Workers’ Fund began its medical work with paraplegia miners. Paraplegia is a common

work-connected accident in the coal industry, due to rock falls “jack-knifing” the miner, fracturing vertebrae, and severing the spinal cord. The newly-developing physical rehabilitation techniques were transposed from the Veterans and Armed Forces hospitals into civilian life and were developed under the impact of this programme, which helped to create many of the first civilian rehabilitation centres in the U.S.A. Another special centre was set up for miners suffering from silicosis.

Starting at a five cent per ton “royalty” for the Welfare and Retirement Fund, 40 cents is now being paid into the Fund on each ton of coal mined. The Fund is a non-profit-making charitable trust, administered by a tripartite Board of Trustees* which administers an extensive general medical care programme (U.M.W.A. Welfare Fund Report, 1952) under the direction of a distinguished public health administrator (Dr. Warren F. Draper). The following medical services are now being provided from the “royalty payments”:

- (1) Hospitalization and in-hospital physician care, paid for in “participating” existing hospitals, for care by “participating” individual physicians or medical groups. Up to the present, a wide free-choice, fee-for-service approach has been taken, the Fund arriving at its own agreements with hospitals and physicians or medical groups. Nursing (convalescent) home care is paid for *in lieu* of hospitalization when it represents a necessary but less expensive active medical management of the case. Custodial care is excluded. Special-duty nursing, when medically indicated, is paid for.
- (2) Specialist office service and hospital out-patient service in participating hospitals by participating physicians.
- (3) Certain specifically listed drugs in certain chronic diseases, selected as likely to be expensive and needed for prolonged use, as well as in-hospital drugs arising from (1) above. Examples are: insulin for diabetes, liver and vitamin B-12 for pernicious anaemia, and streptomycin for tuberculosis.

The programme includes not only the working miner but also his wife and dependent children (including disabled adult children), and other actual adult dependents living under his roof for over 6 months. Unemployed, disabled, retired, and pensioned miners and their dependents, and the widows and orphans of miners are also eligible unless they have forsaken employment in the bituminous coal industry.

* Part of this section is adapted from a paper presented to the “Conference on Current Problems in Administrative Medicine” sponsored by the Institute of Administrative Medicine, Columbia University, New York, 1952.

* At present composed of Mr. John L. Lewis, President of the United Mine Workers of America (Chairman), Mr. Charles Owen, Bituminous Coal Operator Trustee, and Miss Josephine Roche, neutral Trustee and full-time Director of the Fund.

A case-finding approach is maintained, as is the "service" medical economic approach, *i.e.* the entire amount of a reasonable bill for services within the scope of the programme is paid for by the fund without extra payment by the members.

This, of course, is in most striking contrast to commercial indemnity (payment of certain specified amounts of cash *toward* hospital or surgical expense, in some cases covering perhaps only a low proportion of the bill). There are no arbitrary limitations on duration of hospital stay, since it is the purpose of the programme to cover all *necessary* hospital days. Review of hospital stay and the initiation of case disposition activities in order to prevent unnecessary prolongation is undertaken by the Fund's Area Medical Offices, which use public health nurses to good advantage in such situations. There are no excluded disease categories as such (even tuberculosis and mental disease are paid for during diagnostic and short-term hospitalization episodes). Tonsillectomy and dental services are not covered.

Administrative costs as low as 2.9 per cent. have been achieved (Social Security Administration, 1952). This has been partly the result of the volunteer assistance of the members, especially of the local union officers, but it is also partially inherent in the simple method by which the Fund's money is obtained. The royalty is paid on each ton of coal mined at the source, the money being sent directly to the Fund by the coal company. Accordingly, there are no overheads for salesmanship, advertising, premium collection, or other paraphernalia of selling insurance. Economy and quality are also fostered by the fact that the Fund administers its own programme through its own national and ten Area medical offices. This tailors the programme to the mining families' specific needs and creates the atmosphere not of a fiscal liability but of a health programme.

The Fund has utilized the best existing hospitals it could find in or near the mining vicinities, making billing arrangements on an inclusive *per diem* rate based on cost whenever possible. Physicians have been paid primarily on a fee-for-service basis, but retainer and other time-based arrangements are increasing in number.

The experience of the Fund showed that it needed to subsidize the development of new hospital beds near some of the mining communities, since satisfactory hospital facilities either did not exist or were not available to the miners. Accordingly, ten "Memorial Hospitals" are at present being constructed in Kentucky, southern West Virginia, and Virginia, with United Mine Workers' funds. (As might be expected, some of these have met with

medical opposition since they upset the *status quo*.)

Medical Group Practice and the Miners' Fund.—The Fund also has learned that the development of medical group practice in health centres is necessary to enable the provision of comprehensive treatment, with emphasis on preventive, ambulatory, and rehabilitative care.* The previous pattern of home and office care by general practitioners through the so-called "check-off" system (voluntary capitation prepayment for general practitioner office and home calls and some dispensed drugs) was in deserved disrepute among both the miners and their community doctors. This critical situation calls for a replacement of what has been traditionally called the "company doctor" system. Hence, experiments now being made on methods of stimulating medical group practice, but in the framework of a wide free choice of participating physicians, have already promised important results.

Systematic associations of specialists and general practitioners, with an adequate range of auxiliary personnel, and necessary laboratory, X-ray, and other facilities, are being sponsored and stimulated. This type of development makes for a more efficient use of the physicians' time, lower overheads, and a better basis for budgeting payments from the Fund. One key group of medical practitioners is sponsored by a non-profit-making corporation composed of and directed by local and district union leaders who form its Board of Directors. The Board provides the "Community Health Centre" in which the medical group provides service. Further developments of this type are being encouraged.

3. DIRECT SERVICE PLANS

Another major American trend in providing medical care has been the growth in the number of Union Health Centres. Diagnostic or treatment facilities are maintained at a central point near the trade union member's place of employment, either by his health and welfare fund or by his trade union.

The first of these, the Union Health Centre of the International Ladies Garment Workers' Union (A.F. of L.), was established in 1913 after the New York City garment workers' strike of 1910 (Price, 1946). It is now transferred to and partially supported by a union health and welfare fund. Some twenty smaller health centres modelled on the original New York Centre are now maintained in various communities throughout the United States by the I.L.G.W.U. Women form the large majority of the membership of

* Medical group practice in the United States was reviewed by McKeown (1948). Since that time a summary monograph and a chapter on the subject have appeared (Hunt and Goldstein, 1951; Goldstein, 1952). See also Falk (1949) and Parran (1953).

this union. The parent centre now occupies a building with 100,000 square feet of space; some 175 part-time and nine full-time physicians handle some 1,800 patients per day. No home calls are made except as part of the administration of a disability indemnity programme.

The Labour Health Institute of the Teamsters' Union (A.F. of L.), in St. Louis, Missouri, arose in 1945 from a collective agreement which by 1949 covered some 8,000 members (Richman, 1949). It provides a very comprehensive range of medical services, even including (as is unusual in the United States) considerable prepaid dental care. The quality of service is reported to be high.

The Amalgamated Clothing Workers (C.I.O.), the counterpart in the men's clothing industry of the I.L.G.W.U., which has built monumental ambulatory health centres in many cities* through its medical benefit funds, stresses preventive services. These centres are financed by 3½ per cent. of wages (2 per cent. from the employer and the rest from the employee).

The New York Hotel Trades Council, through its Hotel Association Health Centre, developed its own medical facilities in 1950 (Guidotti, 1953).

What may be a new trend has manifested itself in Philadelphia, where eleven constituent unions combined in an "American Federation of Labour Medical Service Plan" (McDonough, 1952). Such examples of co-operation between inter-craft trade unions are uncommon in the health field. If they spread, they can be of tremendous moment to the future of medical care in the U.S.A. Stirrings in a similar direction are to be found in Chicago, Illinois, where a Union Health Centre is planned, spearheaded by the Janitors' Union (A.F. of L.).

In San Francisco, to cite another episode, a resolution was passed (Weinerman, 1952) that some 100,000 members in A.F. of L. unions should develop such an inter-craft union health centre. This was voted unanimously by its Council following the recommendations of the Wienerman Report, so named after its author. This action aroused great apprehension in medical circles, because it seemed that it would involve a majority of the population of the city and thus set in motion vast changes. Perhaps as a result of this medical apprehension, no action has been taken, even though the 100,000 members of the A.F. of L. are still unanimously on record for it.

4. EVALUATION OF COLLECTIVE BARGAINING FOR MEDICAL CARE BENEFITS

It should be understood that the self-administered funds (such as that of the Mineworkers) and the

* e.g. New York City, Philadelphia, and Chicago.

direct service centres (such as those of the Garment workers) represent an *avant garde*. The great majority of the benefit agreements are essentially company administered, and frequently commercial insurance company administered. Most of them provide only a certain amount of cash toward meeting part of in-hospital (and surgical) expenses and toward some wage replacement in the event of disabling illnesses of between one and 24 weeks*. Some, such as the United Automobile Workers and the United Steel Workers (C.I.O.), have benefits under nation-wide Blue Cross and Blue Shield contracts.

The reason is easy to see. The ease with which workers in different plants in different parts of the country could be offered relatively uniform benefits through these mechanisms is clear, but the creation and operation of direct service plans would not only be difficult but would also disturb existing patterns of medical practice. Both hospitals and physicians prefer traditional methods of assuring payment, and neither have had to adjust very greatly as a result of the developments to date. The plans obviously give the worker a *certain* amount of security and have broken down *some* of the financial barriers to the receipt of medical care which he formerly faced.

However, the Blue Cross, Blue Shield, and commercial insurance plans are seriously lacking in any emphasis on prevention, health education, early diagnosis, rehabilitation, geriatric care, and other aspects of a sound preventive health programme. The fiscal basis of many commercial plans for medical indemnity makes no provision for health conservation through periodic health examinations, immunizations, and maternity and child-health instruction. Where home and office care is excluded, there remains a financial barrier to early and preventive care, and to treatment for the home-bound chronically-ill patient. The quality of the medical care provided under cash indemnity is considered to be "none of the plan's business".

Any limited (non-comprehensive) plan of medical care increases the nation's hospital bills unnecessarily, because many cases are admitted to hospitals and retained longer than would otherwise be the case because of the financial incentive of in-hospital admission to both patient and doctor, since hospital days are prepaid but home and office care are not. Dependent's benefits are usually inadequate, but the bills must be paid by the worker. "Adverse risks" of various types are excluded. In at least some

* We have more or less neglected temporary disability indemnity in this paper. In the United States most of this is now on a commercial insurance basis, although some is administered through employees' mutual benefit societies and other self-insurance mechanisms. In a few states (Rhode Island, California, New York, and New Jersey) it is on a state-wide social (compulsory) insurance basis (Sinai, 1949).

communities, surgical charges to the patient have risen each time the rates of surgical indemnity fees were raised, so that the surgeon, but not the patient, gained financially.

A significant amount of the premium dollar goes into medically unproductive items, such as brokers' commission, salesmen's profits, advertising, collecting expenses, etc. For reasons of national pride, we will not refer to allegations of corruption, such as the direct or indirect bribes which may be offered to officials in industry or labour who have the power of awarding a contract to a particular insurance carrier. Administratively, the filing of claims, individual processing, etc., is little less than a monstrosity. Re-duplication, uneconomical size, inappropriate competition, etc., all abound. Little opportunity is provided for the workers' self-administration or for their representation on policy bodies.

The inadequacies of in-hospital insurance and the limitations of surgical benefits are so apparent that a break in the direction of medical group practice sponsorship linked with medical care insurance is clearly indicated. The Health Insurance Plan (H.I.P.) of Greater New York (Baehr, 1950), and the Permanente Health Plan of the Kaiser industries (Garfield, 1952) are two important developments in this direction. Both are based consciously and articulately on:

- (a) group prepayment of the costs of medical care,
- (b) medical group practice to render and purvey it,
- (c) financial inducements to prevention of illness,
- (d) overall responsibility of groups of physicians for the total health of groups of people, especially of families.

5. DISCUSSION

What are the probably continuing and future trends in the field of medical service plans sponsored by trade unions? Perhaps the following remarks are relevant:

(i) *Medical care programmes created by trade unions* are an important and growing facet of the medical care system in the United States. The trade unions are developing an informed nucleus of personnel who know the specific needs of their own members and their families, and how those needs can be met. Their voices increasingly carry weight in labour-management negotiations at every level.

(ii) If any *Federal medical care programme* were to be enacted in the near future (and this is remote under the present administration), it would inevitably be quite different from any programme proposed but not enacted in 1943. Some future administration would utilize the newer trade union direct service facilities, and probably also, at least at first, the trade union fund administrative mechanisms, since these have built up a body of per-

sonnel, experience, and practice which could not be lightly disregarded, just as would Blue Cross, Blue Shield, and even commercial insurance. The ultimate trend might be the direct government administration of an analogue of the British National Health Service, but such an outcome does not yet appear to be on the horizon.

Other estimates of the direction of present trends may be listed as follows:

(i) *Comprehensive medical care* prepayment is increasingly important. The provision of office and home care, and of preventive and rehabilitative services, in addition to in-hospital care, seems to be on the increase.

(ii) *Medical group practice* is growing as a key device in the development of quality and economy of service. This will, of course, be combined with a continuing need in isolated communities for individual practitioners, but even they will thus be backed up by a team of personnel and facilities on a "regional" basis. The broadened health team would include the visiting nurse, the dentist, the trained non-M.D. medical care administrator, and the social worker.

(iii) *More mature relationships are developing with public programmes of health and welfare.* Such a development is typified by the mobilization and attempts at improvement of the State Vocational Rehabilitation Schemes, backing of the formation and development of the Public Health Department Services, the Welfare Departments, and other organizations for public medical care.

(iv) *Teaching and research activities* are beginning to grow, with ties to the medical, public health, and related health professional schools.

(v) Integration with *workmen's compensation* and the *occupational health services* is beginning to develop.

(vi) *More mature social and community planning* is developing as part of an emphasis on primary prevention and positive health conservation.

6. SUMMARY

(1) Through collective bargaining by trade unions, organized medical care plans have exhibited a striking growth in the past decade in the United States of America.

(2) Hospital and surgical coverage has been the commonest form of medical plan, "comprehensive" medical care being unusual.

(3) The United Mine Workers Welfare Retirement Fund is described in detail.

(4) Direct service medical group practice plans are on the increase.

(5) Present methods and plans are evaluated.

(6) The existence of these plans will probably influence the provisions of any future national health insurance legislation.

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