Organized Labor's Impact on the Healthcare Industry: Unions in the Time of Reform

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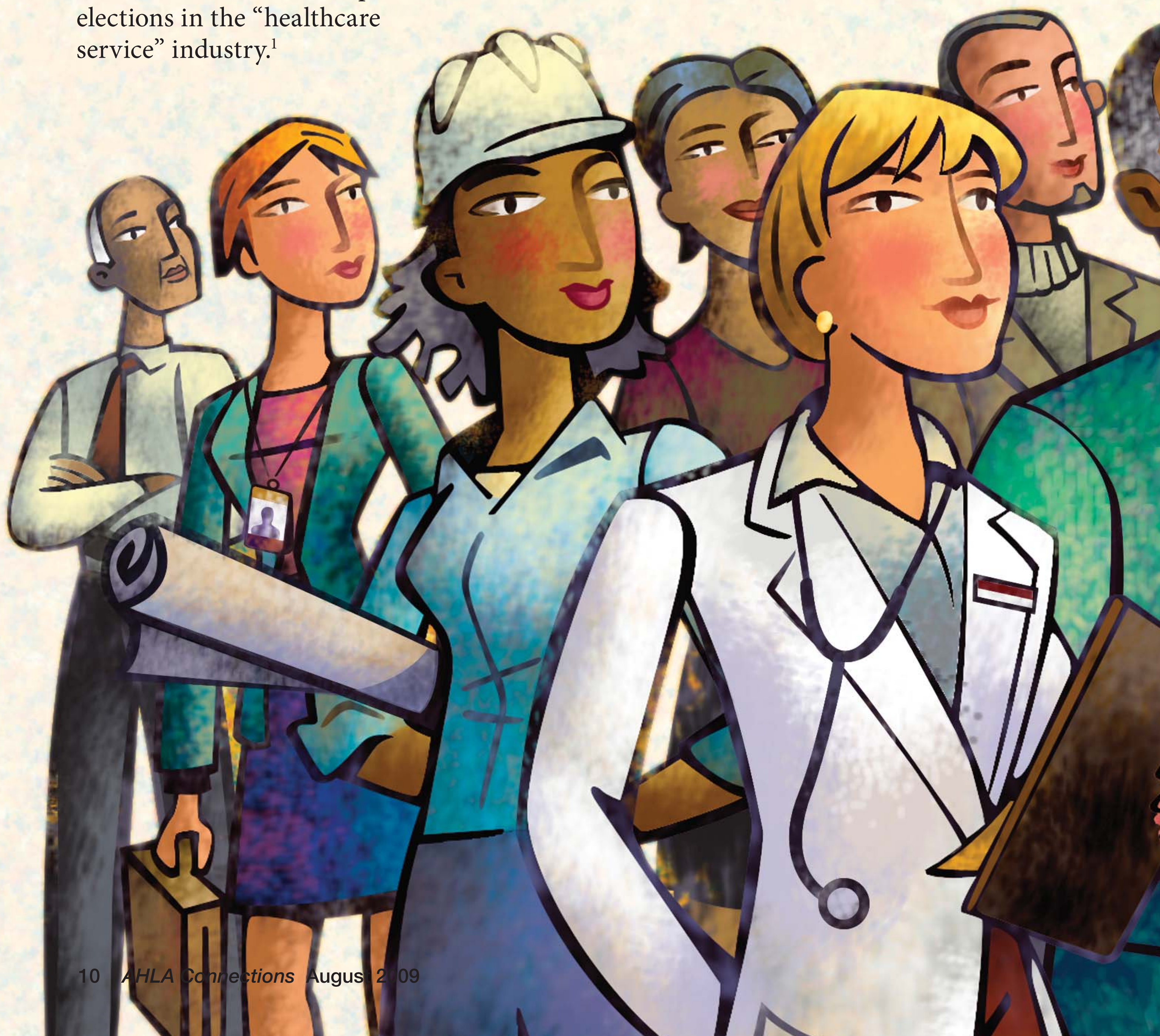
Much has been written about the decline of organized labor in the United States. The number of union-represented employees in the private workforce has plunged from a high of 35% in the mid-1950s to under 8% today. The trend is otherwise in the healthcare industry. Organized labor's role in healthcare has grown from modest beginnings, at least when measured by the number of National Labor Relations Board (NLRB) representation elections conducted in the industry. In 1966 and 1967, the NLRB conducted a total of 12 representation elections in the "healthcare service" industry.[1]



In 1967, however, the NLRB extended its jurisdiction to private for-profit hospitals. Not surprisingly, union organizing in healthcare took off as a result. During the period from 1968-1974, unions won upwards of 60% of nearly 1,400 NLRB-conducted representation elections in the healthcare services industry.[2]

In August 1974, Congress further extended the NLRB's jurisdiction to nonprofit hospitals. This watershed event resulted in an explosion of union organizing in the industry. NLRB healthcare representation elections zoomed to 579 in 1975, peaked at 746 in 1977, and ranged from 296 to 695 each year during the period from 1978-1993.[3] During that time period, unions typically won well over 50% of the elections conducted.

As of 2008, unions represented over 1.3 million employees in hospitals, long term care facilities, home healthcare, and other healthcare-related settings.[4] Moreover, unions are winning nearly 75% of elections conducted by the NLRB at healthcare-related employers.[5] This far outstrips the union win rate in other industries as well as the percentage of union victories in healthcare from just a few years ago.[6] Unions such as the Service Employees International Union (SEIU), the California Nurses Association/National Nurses Organizing Committee (CNA/NNOC) (which recently announced a merger with the United American Nurses and the Massachusetts Nurses Association), the American Federation of Teachers Healthcare Division (AFT), the American Federation of State, County and Municipal Employees (AFSCME), and the newly formed confederation of several state nursing associations called the National Federation of Nurses have all announced that the healthcare industry is a primary target for organizing. They clearly understand what is at stake, i.e., large numbers of potential members in an industry that is certain to grow and whose jobs are difficult to send off-shore. Coupled with the current efforts in Congress to make it easier for unions to organize employees in general,[7] there seems to be little doubt that union representation in healthcare will continue to increase in the near future.

These same unions also are active participants in the current healthcare reform debate. After having contributed millions of dollars to Democratic candidates in last fall's campaigns,[8] organized labor has secured a seat at virtually every table where healthcare reform is the topic. As of this writing, uncertainty as to the eventual outcome of these debates still prevails. Some unions appear to support one set of solutions while others suggest other variations. With few exceptions, the one thing that all unions publicly support is a reduction in the cost of healthcare.[9]

All sectors of the healthcare industry are labor intensive. For example, it is estimated that roughly 60% of a hospital's costs are for labor. Presumably, and certainly impliedly at this point, some unions contend that there is sufficient fat in the non-labor portion of providers' overall costs to simultaneously fulfill the unions' promises and duties to healthcare employees they represent and reduce the cost of healthcare. Others seem to promote additional taxes to support universal healthcare and/or reform.

While analogies are often dangerous, these arguments are similar to those made by the United Auto Workers in discussions with the big three auto companies prior to the current crisis in that industry. Just as dropping sales forced the auto manufacturers to find ways to lower their labor and other legacy costs, it is unlikely that reform will succeed in reducing overall healthcare costs without curbing the growth of providers' labor costs.

Often lacking from the cost reduction proposals put forth by organized labor are details regarding the direct impact of such reductions on healthcare employees they represent or seek to represent. The

SEIU acknowledged in its submission to President Obama dated June 1, 2009,[10] that "bending the cost curve will involve major changes in the operations of healthcare institutions and these changes will have a major impact on our more than one million healthcare members." Its proposed initiatives, however, emphasize expanded home- and community-based services, chronic care and prevention, and post acute care payment reform without any analysis or further discussion of the myriad labor issues that such changes would entail. An analysis of these effects is similarly lacking from the submissions of the other healthcare groups who, collectively, have pledged to "help cut $1.7 trillion of healthcare costs over the next decade."[11]

The lack of such detailed analyses is not necessarily surprising. For healthcare unions, this may well be the "never to be touched third rail" of the reform debate. But, as with many things, the devil is in the details. Those unions whose membership includes only a small percentage of healthcare workers are in a position to lobby for reduced healthcare costs without worrying too much about the impact of such reductions on healthcare workers. Those who represent a significant number of healthcare employees will, unfortunately for the industry as a whole, find themselves on the horns of a dilemma as they support reductions in overall healthcare costs while attempting to add new members and vigorously represent the interests of their members in collective bargaining. Simply put, this is an inherent conflict that can be ignored for only so long. Given that retaining and increasing membership is the only way a union can remain viable, it is suggested that healthcare unions will ultimately bend to the immediate desires of the employees they represent or seek to represent rather than continuing to support healthcare cost reductions.

To retain the employees they already represent, unions must be able to convince them that the services the unions provide in return for the dues paid are worth it. In order to grow, they must convince employees they seek to represent that they can deliver better wages and benefits or improved working conditions. Few employees are willing to voluntarily pay from their own pockets for services that do not appear to benefit them directly. When unions are at the bargaining table or engaged in a campaign to organize healthcare workers, they recognize that they must promote those issues that appeal directly to the affected employees—the so-called "bread-and-butter" issues. Job security, minimum staffing ratios, increased wages and benefits, defined benefit pension plans, and restrictive work rules such as limitations on temporary transfers between units or jobs ("floating"), or sending employees home when census or workload is down ("call-offs") are just a few of the promises that unions make or attempt to obtain in negotiations to secure and retain employee support. Healthcare unions also actively promote legislation, most often at the state level, that would or currently do mandate staffing ratios, place restrictions on overtime, require additional staff to relieve for rest and meal breaks, and require similar measures that increase provider costs and directly impact the terms and conditions under which healthcare employees work. Whether or not one is sympathetic with these efforts, it is evident that all of these goals increase, rather than decrease, the cost of labor for any healthcare-related entity.

So, what does healthcare reform, in whatever form it eventually takes, mean for healthcare industry employers? For those whose employees are already represented by a union, it probably means even more contentious negotiations and increased grievances and arbitrations. Adoption of improved technology that displaces workers is a mandatory subject of bargaining under the National Labor Relations Act and under most state laws that regulate collective bargaining in state or local governmental institutions. So too are reductions-in-force that would result from the shifting of services from the long term care institutional setting to home- and community-based services. Wage increases, skill mix, retirement programs, reductions-in-staff, work rules or restrictions, staffing ratios, and virtually all other terms and conditions of employment fall into this same category. Employers must bargain in good faith with the union representatives of their employees regarding all of these issues. Stated another way, no healthcare employer can unilaterally make changes in its represented employees' terms and conditions of employment without bargaining with their employees' union representatives.

Union insistence on increased job security, significant wage increases, adoption or continuance of defined benefit pension plans, or implementation or continuation of restrictive work rules places the healthcare employer between the "rock" of decreasing or shifting reimbursements and the "hard place" of potential strikes or other labor-related disruptions. It is naïve to assume that a healthcare union, driven by its need to satisfy the desires of the bargaining unit employees it represents, will readily recognize that cost containment requires concessions by its members, especially when they also realize that other unions stand ready in the wings to raid their membership if they are perceived by those they represent as being "soft" in supporting their interests.[12] "NIMBY" ("Not in my back yard") is the likely response when an employer makes such proposals in collective bargaining. And, even where unions proactively work with healthcare employers to implement new strategies, they are required by law to "fairly" represent their members.

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Politically and legally, it is difficult for a union to tell an employee who is negatively impacted by the kinds of changes that healthcare reform is likely to bring about that his/her grievance or concern is not meritorious. At a minimum, it must be anticipated that unionized healthcare employers will have to devote significantly more resources to dealing with these issues than has been the case in the past and that they will be faced with increased risk of strikes or other labor-related disruptions.[13]

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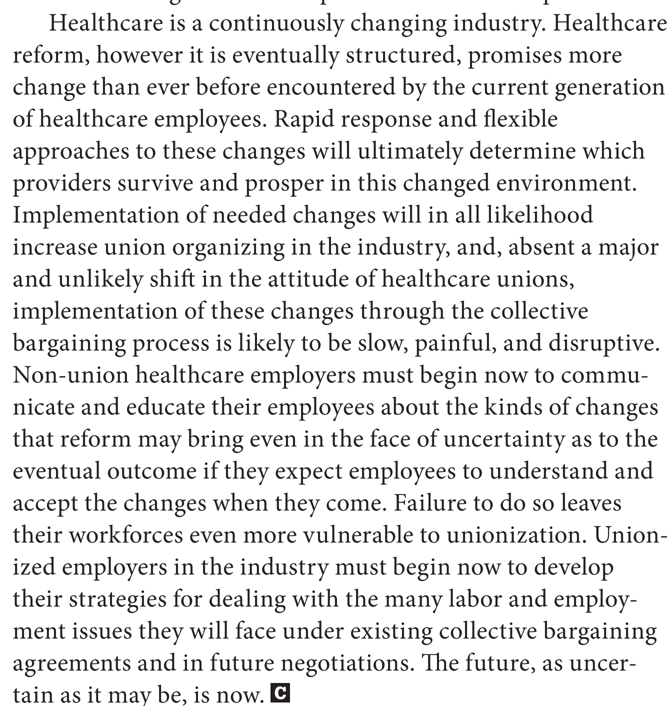
It is equally naïve to believe that unions will refrain from promises of enhanced job security, increased wages well beyond increases in reimbursements, better benefits, or other costly improvements in working conditions as they seek to grow their membership among currently unorganized healthcare workers. In many cases, healthcare employees are drawn to unions who promise to protect them from the very changes that healthcare reform seeks to promote. The union organizers' playbook is fairly simple. Find out what the employees they are trying to organize want and convince them that being represented by the union will get it for them. At the very least, it is doubtful that this will change because of healthcare reform and the almost universal recognition that healthcare costs must be reduced. Unions recognize that employees must believe that they will be better off with union representation if they are going to sign union authorization cards or vote for union representation. They further understand that convincing healthcare employees that obtaining universal coverage or reducing the overall cost of healthcare for everyone in the United States is a direct benefit to those employees is a hard if not impossible "sell." Assuming the union is successful at creating these expectations in an organizing campaign, it must then attempt to satisfy them when it goes to the negotiating table on behalf of these employees or risk alienating them. And so, the circle continues.

Given these circumstances, it is even more significant that no healthcare reform proposal thus far contains incentives for unions to avoid or even reduce the number of incredibly costly "corporate campaigns" against healthcare employers. These campaigns typically involve systematic attempts by a union to so demonize a targeted employer to patients, the community, government regulators, and other constituencies that the employer eventually agrees to assist the union in the union's organizing efforts or, at a minimum, not oppose them. Defending against and repairing the damage caused by this massive negative publicity, whether the union's allegations are true or not, saps the resources of any employer so targeted. However, healthcare unions have found that such campaigns can increase their membership even in the face of employee resistance. The lofty goal of reducing healthcare costs to millions of Americans again gives way to the healthcare unions' ultimate need to increase their only real source of revenue—the dues, fees, etc. of the employees they represent. From their perspective, this is survival. Employers, politicians, or others who ignore that simple fact do so at their peril.



Healthcare is a continuously changing industry. Healthcare reform, however it is eventually structured, promises more change than ever before encountered by the current generation of healthcare employees. Rapid response and flexible approaches to these changes will ultimately determine which providers survive and prosper in this changed environment. Implementation of needed changes will in all likelihood increase union organizing in the industry, and, absent a major and unlikely shift in the attitude of healthcare unions, implementation of these changes through the collective bargaining process is likely to be slow, painful, and disruptive. Non-union healthcare employers must begin now to communicate and educate their employees about the kinds of changes that reform may bring even in the face of uncertainty as to the eventual outcome if they expect employees to understand and accept the changes when they come. Failure to do so leaves their workforces even more vulnerable to unionization. Unionized employers in the industry must begin now to develop their strategies for dealing with the many labor and employment issues they will face under existing collective bargaining agreements and in future negotiations. The future, as uncertain as it may be, is now. C

Ron Kimzey (rkimzey@fordharrison.com) represents employers throughout the country in all aspects of labor and employment law, including traditional labor law and employment litigation. He assists clients in strategic labor planning, mergers/acquisitions, collective bargaining, management training and development, litigation and arbitration, risk management and union avoidance. Ron is an active speaker on labor and employment issues and is a member of the Ford & Harrison Executive Committee. In addition to serving clients in multiple industries, Ron is Chair of Ford & Harrison's Healthcare Practice Group. This practice group focuses on the many labor and employment issues unique to hospitals, long term care and assisted living providers, physician practice groups, and healthcare-related companies of all types. Ron has advised healthcare industry employers on labor and employment matters for over 35 years, and is based in the firm's Atlanta, GA office.

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Endnotes

1 Barry T. Hirsch & Edward J. Schumacher, *Union Wages, Rents, and Skills in Health Care Labor Markets*. 19 J. K@ANQ QDRD@QBG 125-47 (1998), Table 5 Union Organizing Activity and Membership Density in the Health Care Industry.
2 *Id.*
3 *Id.*
4 U.S. Department of Bureau of Labor Statistics, TMHNM LDLADQR in 2008, Table 3 Union affiliation of employee wage and salary workers by occupation and industry (Jan. 28, 2009).
5 NLRB Election Statistics, Year End 2008 Report, at p. 17.
6 NLRB Election Statistics, Year End 2008 Report.
7 In particular, the proposed Employee Free Choice Act (EFCA) would amend the National Labor Relations Act to require card check recognition, mandatory interest arbitration, and increased employer penalties for unfair labor practices. The card check process in particular would make it easier for unions to organize by effectively eliminating secret ballot elections and replacing them with a procedure in which a union could secure representational rights solely on the basis of signed union authorization cards from a majority of employees.
8 Alyssa Rosenberg, *Business: It's Not Just 'Card Check'*, M@S&K J., Feb. 14, 2009.
9 *See, e.g.,* @CCQDRR AX INGM RVDDMDX+ OQDRHCDMS NE @EK,BHN+ SN M@SHNM@K @B@CDLX NE RNBH@K HMRTQ@MBD BNMEDQDMBD HM V@RGHMFSNM+ C-B. on Jan. 29, 2009, entitled *Curbing High Health Costs: The Linchpin for Successful Health Reform*" briefed in M@S&K @B@CDLX NE RNBH@K HMR- GD@KSG @MC RDBTQHSX HMBNLD AQHDE, No. 14., Apr. 2009.
10 *SEIU's Submission: Proposals to Bend the Cost Curve, June 2009*, submitted to President Obama as part of submissions from Advanced Medical Technology Association, America's Health Insurance Plans, the American Hospital Association, the American Medical Association, the Pharmaceutical Research and Manufacturers of America, and the Service Employees International Union (June 1, 2009), *available at* www.aha.org/aha/letter/2009/090601-let-health-groups-obama-cost-con.pdf (last visited June 8, 2009)).
11 Janet Adamy, *Health Groups Detail Plans to Reduce Costs*, V@KK RS- J., June 2, 2009, at A3.
12 A good case in point is the current battle between the SEIU and the National Union of Healthcare Workers (NUHW). SEIU recently removed the officers of its United Healthcare Workers - West local and imposed a trusteeship. The deposed officers formed a new union (NUHW) that has been systematically attempting to raid the bargaining units now represented by SEIU in California.
13 In the heavily unionized San Francisco Bay Area, nurses, many of whom have two-year Associate degrees, have compensation that often rivals that of physicians. While this is due in part to a nursing shortage exacerbated by the nation's only state-mandated nurse-patient ratios in hospitals, it is also a consequence of the frequent strikes called by healthcare unions in that area over the past two decades.