

Attitudes of Organized Labor Officials toward Health Care Issues: An Exploratory Survey of Alabama Labor Officials

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Abstract:

Delegates to the Alabama AFL-CIO Convention were surveyed concerning their attitudes toward their health benefits and various options for health care reform. Most are satisfied with their current health care coverage, but dissatisfied with its high costs. Participants attribute the high costs to providers' pricing policies and insurance companies' overhead.

Key words: health insurance; health reform; labor negotiations; unions

Article:

Throughout the 1980s and early 1990s organized labor's influence and bargaining power had been eroding. As the nature of American industry changed from one of smoke stacks and factories to service and technologies, union strongholds began to fall. Traditional union industries, such as automobile and steel manufacturing, closed older plants and moved to new locations and started fresh-often without unionized labor. Furthermore, many companies began using part-time and temporary employees to avoid paying benefits other than wages.

Even when unions were brought into new factories the relationship between management and the work force was closer. The groundbreaking partnership between unionized employees and management at General Motor's Saturn plant, in Spring Hill, Tennessee, is a prime example and the cooperative agreement was reaffirmed by workers in March 1998. The role of the national labor organization appeared to be diminishing in the lives of the rank-and-file union members.

However, other recent events indicate that national unions are still a force to be reckoned with and that they have the ability to compel a company to bargain. The United Parcel Service (UPS) strike in 1997 and the General Motors (GM) walkout in 1998 showed that the Teamsters and United Auto Workers (UAW) had adapted their negotiating strategies to the new work environment. Prior to going on strike, the unions waged public relations campaigns, stating their positions on part-time workers and job exportation, respectively. The messages resonated positively with an American public who had witnessed a decade of corporate downsizing and diminished benefits in the jobs that remained.

Unusually absent from much of the UPS and GM negotiations was the debate on health insurance coverage. For many years wages, health care, and pension benefits were the primary focuses of national labor contract negotiations. Clearly, health care is currently a major political topic. Why have unions chosen to neglect the issue in their recent conflicts?

There is other evidence that health insurance is less important than other labor issues to union negotiators. Local unions have been willing to move from fully indemnified insurance to managed care models in exchange for higher wages and longer contracts. Large unionized employers such as Disney, Nabisco, the

State of New Jersey, GM, Ford, and Chrysler have successfully negotiated for the use of managed care, larger copayments, and increased rates of coinsurance in recent years.[1-4](#) The high levels of satisfaction and importance placed on health benefits by members would seem to be powerful incentives for unions to cling to the status quo.

Further evidence that unions want to remove health care from the negotiation process is apparent at the national level. Organized labor was one of the major lobbies supporting President Clinton's failed health care reform proposals in 1994.[5,6](#) Whether or not the AFL-CIO's support for health care reform represents the views of members and lower-level officials is unknown, since research on this topic has not been conducted. The fact that many unions seemed to be ambivalent about the Clinton health care reform plan may suggest a range of views within organized labor.[7](#)

One possible view is that health insurance negotiations are complicated and misunderstood by the members. Furthermore, even when concessions are gained they may do little to enhance worker loyalty to the union since they are considered a right rather than a privilege. Therefore, it is in union management's best interest to remove insurance from the equation, otherwise they must address a number of specific problems:

- * High rates of health care inflation divert dollars into expensive health benefits thus stifling possible wage growth.

- * Members often take health care benefits for granted. While they insist on maintaining their current health care benefits, they also fault the union for failing to make other monetary gains as well.

- * Millions of union members, accustomed to secure health benefits, were left without coverage as plants closed and corporations downsized during the 1980s and early 1990s.

- * Union members perceive that health care providers charge a premium to those with good insurance plans. They resent the current system because they believe that health care premiums of union workers subsidize the uninsured and underinsured, including nonunion competitors.

With employer-based health benefits projected to reach \$22,000 per employee by the year 2000, the cost-shifting perception is particularly problematic for unions.[8](#) For example, the International Brotherhood of Electrical Workers (IBEW) and the Communications Workers of America (CWA) went on strike against Nynex over health insurance benefits. The belief that \$70-\$80 of each worker's \$197 monthly health insurance premium may be the result of cost-shifting from uninsured patients was referred to by some union advocates.[8](#) Consequently, many unions have worked with management on the local level to contain health care costs.[9](#)

The cost-shifting argument has further implications. Competition from nonunion companies is a major concern of labor unions. The New Jersey AFL-CIO president maintains that the state has a problem with nonunion firms offering no health care benefits at all, enabling them to underbid union contractors on public or private construction projects.[10](#) Again, part of the cost of union contractors is related to their inflated insurance premiums covering the health care costs of their nonunion competitors (due to cost-shifting).

POLITICAL ATTITUDES OF UNION LEADERS AND MEMBERS

For the reasons cited above, unions at the national level have been lobbying for national health care reform for decades.[11](#) Their goal has been to nationalize health insurance coverage so that collective bargaining can focus on other important workplace issues. Yet, the unions' rank-and-file have often not supported their leadership, as evidenced by the failure of union members to support the Clinton health care reform proposal, despite support from most national union leaders.[12](#) The President's plan may have gotten a cool reception from the

rank-and-file membership because they expected more government red-tape and reduced benefits from the proposal.

Historically, labor unions fight for self-interest legislation, as do other groups in our pluralistic society. However, they have scored their greatest political victories on more general societal legislation (such as Social Security, minimum wage, and public education).¹³ Despite a massive lobbying effort by organized labor,⁶ health care reform failed in 1994. Union leaders were divided among themselves concerning which particular health care reform proposal to support.

In 1991, the 16-member AFL-CIO Health Care Committee split 8-8 over whether to recommend a mandated employer-based benefit approach (like the Clinton proposal) or a Canadian-style system of universal coverage supported by general federal tax revenues.⁸ Committee chair and Service Employee's President John Sweeney broke the tie in favor of employment-based reform.¹⁴ It then listed elements any reform should have. These included all payer rate setting, a global U.S. health care budget, a national social insurance program, a national cost containment program, a national commission to administer the program, a core package of health care benefits, employer mandates, standardization of claims forms, elimination of preexisting conditions as a barrier to coverage, expansion of Medicare coverage, a national database on the cost and quality of service, reform of the malpractice system, and inclusion of long-term and chronic care.⁸ Obviously, these elements go far beyond our current employment-based health insurance system so that the committee proposal was a compromise.

Labor union members' political attitudes do not always coincide with those of their leadership. One study of Alabama union members during the 1984 Presidential election found a significant minority supporting Ronald Reagan despite overwhelming advocacy of Walter Mondale among the union leadership.¹⁵ Voting varied by such factors as age, sex, occupation, and industry.

The study on which this article is based addressed the following questions using a sample of union leaders in Alabama:

1. How satisfied are labor union officials with their health insurance coverage?
2. How satisfied are these officials with the cost of their health insurance coverage?
3. What factors do these officials believe unnecessarily contribute to rising health care costs?
4. Who do these officials believe should bear the costs to reform health care?
5. What actions would these officials be willing to take to ensure lifetime universal coverage?
6. How do responses to the above questions vary by the respondent's industry and position in the union?

METHOD

At the 1993-1994 biannual Alabama AFL-CIO convention, 205 delegates were surveyed to determine their attitudes toward health care issues and whether the respondent's industry or position affected these attitudes. Specifically, the authors wanted to determine: (1) the degree of satisfaction respondents had with their level of health care coverage and the cost of this coverage, (2) respondent attitudes toward current health care issues and proposals for reform, and (3) whether satisfaction and attitudes can be differentiated based upon the respondent's industry or union position.

	N	Percent (%)
Industry		
Mining and manufacturing	140	68
Government and public utilities	43	21
Services and not classified	22	11
All respondents	205	100
Union Position		
Local officers	112	55
Activists	70	34
Paid staff	16	8
Unknown	7	3
All respondents	205	100

TABLE 1 RESPONDENTS, BY INDUSTRY GROUP AND UNION POSITION

[Table 1](#) shows the breakdown of survey respondents by industry and union position. Most respondents represent members in the mining and manufacturing sectors. While this is not representative of employment patterns for all of Alabama, it is representative of the unionized sector. We collected detailed data on the respondent's industry and analyzed the responses using a variety of categories to determine which best differentiated the responses. The threefold categorization shown in [Table 1](#) did as well or better than other possible classifications in differentiating the responses. Most of the respondents also held a local union office such as president, secretary-treasurer, or union representative. Union activists are individuals who are not local officers or paid staff. They include worker-elected representatives, such as shop stewards. Paid staff typically hold nonelective staff positions in areas such as research.

Respondents were asked to indicate their union position and industry of employment, and were then asked to answer the survey. To our knowledge, no previous analysis of labor union officials' attitudes toward health care issues exists. The AFL-CIO does not regularly conduct surveys of its national membership, nor does it disclose findings from the few internal membership studies it undertakes. Therefore, any comparison of results from our sample of Alabama union leaders with national or regional union leaders is problematic. Consequently, this survey should be viewed as an exploratory study. As such, it is descriptive and not analytical. Analysis of variance (F-test) was used to determine the significance of differences based on position and industry. Space was provided for additional comments, which will also be summarized in this article.

	Satisfaction with Health Coverage				
	N	Excellent	Good	Fair	Poor/None
Industry					
Mining and manufacturing	139	19.4	37.4	25.2	18.0
Government and public utilities	32	7.0	65.1	23.3	4.7
Services and not classified	22	9.1	31.8	50.0	4.5
All respondents	204	15.7	42.6	27.5	14.2
Union Position					
Paid staff	16	50.0	25.0	12.5	12.5
Local officers	112	16.1	44.6	28.6	10.7
Activists	69	8.7	44.9	27.5	18.8
All respondents	197	16.2	43.1	26.9	13.7

^aF=4.36, p<.01

^bF=3.92, p<.05

TABLE 2 SATISFACTION WITH HEALTH COVERAGE, BY INDUSTRY AND UNION POSITION (IN PERCENTAGE OF DISTRIBUTION)

The survey was administered during a plenary session of the biannual convention. A complete census of the

attendees was taken using a questionnaire. As a result, the respondents are representative of local officers, paid staff, and activists in Alabama labor unions. Therefore, these respondents probably do not represent the American public in either political views or industry distribution (i.e., union officials are more likely to be Democratic and employed in manufacturing than are members of the general public). Moreover, these union officials may not represent the views of union members, as noted earlier.

RESULTS

[Table 2](#) shows the satisfaction of survey respondents with their health care coverage. For this and subsequent tables, the total number of respondents may be less than 205 because some respondents failed to answer every question. About 59 percent rated their own coverage as "excellent" or "good."

Respondents in the service industry category were the least satisfied with their health insurance coverage. Approximately 54.5 percent of respondents employed in the service industries rated their coverage as "fair" or "poor," compared to 43 percent in mining and manufacturing, and a very low 28 percent in government and public utility sectors. These results are not unexpected since service industries typically have much lower levels of employer-based insurance.

One unusual finding is that the paid staff were more likely to rate their coverage as "excellent" or "good" (75 percent) than either local officers (61 percent) or activists (53 percent). Since both the paid staff and other union officials typically have the same health care coverage, the significant difference in their responses may reflect the paid staff's greater knowledge of health plans available to nonunionized workers and an appreciation of their excellent coverage. Furthermore, this difference may lend support to the assertion that many unionized workers take health care for granted.

It should be mentioned that in the industrial core represented by our union respondents, health care benefits have been excellent by any standard. Many unions have negotiated first-dollar, comprehensive coverage. By contrast, nonunion employers typically provide lower levels of health insurance and other fringe benefits.[16](#)

However, union leaders' concern with insurance plans is beginning to increase as the prevalence of managed care and the restrictions associated with it have increased. One of New York State's most powerful labor unions, Local 1199 of the National Health and Human Services Employees Union, is planning to launch its own managed care network for the state's 2.5 million union members.[17](#) They decided to create their own nonprofit health plan out of anger and frustration when their insurer began limiting benefits to union members. Daniel Rivera,[17](#) president of Local 1199, has stated:

We think we can do it better and cheaper ourselves. Our premiums go to purchase care. We have no million dollar salaries, no high paid boards, and no golden parachutes. We hope that other unions and perhaps some small businesses will buy into the plan instead of paying premiums to a commercial insurer. (p. 9)

[Table 3](#) indicates there is significant dissatisfaction with the costs of health insurance coverage among respondents. Approximately 53 percent believe the cost of their coverage is either "too high" or "much too high." Again, the opinions of the paid staff differed from other respondents, although there were no differences in out-of-pocket costs for the two groups. Paid staff were more concerned about high costs than were the other respondents; 81 percent felt their costs were "much too high" or "too high" compared to 51 percent of local officers and 49 percent of activists. The paid staff may be more sophisticated about health insurance, more aware of cost shifting arguments, and, therefore more dissatisfied with the costs of insurance. The fact that 100 percent of the paid staff felt hospitals engaged in overcharging ([Table 4](#)) may also point to a belief in cost shifting.

	Satisfaction with Cost of Coverage				
	N	Much Too High	Too High	Fair	Too Low/Much Too Low
Industry					
Mining and manufacturing	132	15.2	35.6	34.1	15.1
Government and public utilities	42	16.7	40.5	35.7	7.1
Services and not classified	21	33.3	23.8	38.1	4.8
All respondents	195	17.4	35.4	34.9	12.3
Union Position					
Paid staff	16	43.8	37.5	18.8	0.0
Local officers	107	15.9	37.4	35.5	11.2
Activists	65	13.8	35.4	35.4	15.4
All respondents	188	17.6	36.7	34.0	11.7

*F=1.43, n.s.
 *F=4.69, p<.01

TABLE 3 SATISFACTION WITH COST OF HEALTH COVERAGE, BY INDUSTRY AND UNION POSITION (IN PERCENTAGE OF DISTRIBUTION)

Factors	All Respondents	By Industry				By Union Position			
		MinMfg	GovUtil	ServNC	p ¹	Paid Staff	Local Officers	Activists	p ¹
Excessive charges by hospitals	89.8	82.2	88.4	85.0	n.s.	100.0	90.7	87.9	n.s.
Excessive charges by physicians	83.8	88.8	93.0	90.0	n.s.	87.5	84.4	83.3	n.s.
Excessive premiums by insur. Co.	56.6	52.6	65.1	65.0	n.s.	75.0	54.1	59.1	n.s.
Excessive administration/paperwk	56.3	53.0	65.1	60.0	n.s.	81.3	58.3	51.5	.10
Malpractice insurance/fear of lawsuits	53.8	47.8	69.8	60.0	.05	62.5	52.8	57.6	n.s.
Excessive medical tests	42.6	42.5	37.2	55.0	n.s.	62.5	43.5	39.4	n.s.
Patient abuse of the system	42.1	42.5	44.2	35.0	n.s.	50.0	41.3	46.4	n.s.
Inadequate consumer information	40.4	40.0	39.5	45.0	n.s.	56.3	41.3	34.8	n.s.
Inefficient provider practices	36.9	38.5	30.2	40.0	n.s.	62.5	39.4	28.8	.05
Inadequate consumer incentives	31.3	30.4	32.6	35.0	n.s.	37.5	33.0	30.3	n.s.
Excessive services: terminally ill	14.6	12.6	18.6	20.0	n.s.	31.3	13.8	12.1	n.s.
All Factors ()	49.8	48.3	53.1	53.6		62.4	50.2	48.2	n.s.

¹Statistical Significance of F-value
 MinMfg = Mining and Manufacturing
 GovUtil = Government and Public Utilities
 ServNC = Services/Not Classified

TABLE 4 PERCENTAGE OF RESPONDENTS WHO BELIEVE VARIOUS FACTORS UNNECESSARILY CONTRIBUTE TO HEALTH CARE COSTS

The general satisfaction of the respondents with their health insurance coverage, coupled with their general dissatisfaction with its cost have created some ambivalence toward various health care reform proposals. Several respondents questioned the effect health care reform would have on their present coverage. They were concerned that either the comprehensiveness or quality of their present insurance coverage might be reduced under health care reform. This is a serious concern, because 71 percent of our respondents indicated that health insurance was the most important issue discussed in the last round of contract negotiations. Previous research has shown that 55 percent of strikes in 1990 were the result of employer efforts to reduce or modify health care benefits.¹⁸

[Table 4](#) displays the various factors that may unnecessarily add to health care costs and union officials' opinions about them. The respondents identified excessive charges by hospitals and physicians as major problems. Excessive administration and paperwork from insurance companies are also considered major contributors to health care cost increases. Note that none of these factors requires change on the part of the respondents. All identify the problems as emanating from others. These results are similar to those found by Blendon and colleagues ¹⁹ in their survey of the general public. Their research showed that Americans

blamed physicians, lawyers, and insurance companies (rather than themselves) for the system's problems. There were few significant differences by industry or position in our survey. Respondents in government, public utilities, and service industries were most concerned about lawsuit abuse while paid staff were more concerned about paperwork and inefficient provider practices.

The emphasis on excessive charges by providers and health insurance companies is consistent with the AFL-CIO "principles of health reform."⁸ This document proposes that the federal government "establish a national cost containment program that includes a cap on health care expenditures, a capital budget that manages the uncontrolled duplication of technology and improves the allocation of resources, and a federal authority that negotiates uniform reimbursement rates (with hospitals, doctors, and other providers) to be used by all payers."^{8(p.43)} Several of our respondents commented about excessive physician charges and incomes and suggested the necessity for caps on the charges of health care providers and insurance companies.

Individuals and Institutions	All Respondents	By Industry				By Union Position			
		MinMfg	GovUtil	ServNC	p ¹	Paid Staff	Local Officers	Activists	p ¹
Federal government ("sin tax")	60.1	66.7	46.5	45.0	.01	66.7	60.6	59.7	n.s.
Large corporations	58.6	60.7	48.8	65.0	n.s.	80.4	56.0	59.7	n.s.
Health care providers	42.9	45.2	44.2	25.0	n.s.	46.7	40.4	47.8	n.s.
Federal government (general tax)	37.4	34.1	46.5	40.0	n.s.	46.7	37.6	35.8	n.s.
Small companies	17.7	17.0	16.3	25.0	n.s.	53.3	17.4	11.9	.01
Individual users	16.2	14.1	23.3	15.0	n.s.	33.3	14.7	14.9	n.s.
Medicare/Medicaid recipients	8.6	8.1	11.6	5.0	n.s.	6.7	9.2	9.0	n.s.
State government (general taxes)	8.6	5.2	14.0	20.0	.01	13.3	8.3	7.5	n.s.
All respondents ()	31.3	31.4	31.4	28.1		34.7	30.5	30.9	

¹Statistical Significance of F-value

MinMfg = Mining and Manufacturing

GovUtil = Government and Public Utilities

ServNC = Services/ Not Classified

TABLE 5 RESPONDENT BELIEFS CONCERNING WHO SHOULD BEAR THE ADDITIONAL COSTS TO REFORM HEALTH CARE, BY INDUSTRY AND UNION POSITION (PERCENTAGE DISTRIBUTION)

Table 5 shows who the respondents think should bear the additional costs of health care reform. Most (60 percent) believe the burden should fall on the federal government (through the use of "sin taxes"), large corporations (59 percent), and health care providers (43 percent). The emphasis on sin taxes is consistent with research by Jacobs and Shapiro,¹⁸ which found the majority of Americans supported increased taxes on liquor and cigarettes. There were a few significant differences based upon industry and position. Those in mining and manufacturing were more likely to favor a federal government sin tax but less likely to favor an increase in state government taxes. Moreover, paid staff were more likely than other respondents to favor having small business bear the increased costs of reform.

The respondents' emphasis on the federal government is also consistent with the AFL-CIO principles for health care reform. These principles include establishing a national social insurance program that includes both workers and the unemployed, incorporates Medicare and Medicaid, guarantees a core package of health benefits, and funds the plan through progressive and equitable federal financing.⁸ It is noteworthy that many respondents did not believe new taxes would be needed, expressed reservations about the federal government's ability to administer a federal health program, and indicated all citizens should have access to basic health services.

Actions	All Respondents	By Industry				By Union Position			
		MinMfg	GovUtil	ServNC	p ¹	Paid Staff	Local Officers	Activists	p ¹
Pay more taxes	52.3	50.7	58.1	50.0	n.s.	66.7	53.2	51.5	n.s.
Accept a cap on benefits	26.9	26.1	20.9	45.0	n.s.	20.0	20.2	36.4	.05
Accept an assigned physician	22.3	18.7	20.9	50.0	.01	33.3	24.8	18.2	n.s.
Pay more for office visits	20.8	22.4	16.3	20.0	n.s.	26.7	22.2	19.7	n.s.
Pay higher monthly premiums	19.8	20.9	20.9	10.0	n.s.	26.7	16.5	24.2	n.s.
Wait longer for routine care	10.2	7.5	18.6	10.0	n.s.	20.0	9.2	9.1	n.s.
All actions (mean)	25.4	24.4	26.0	30.8		32.2	24.3	26.5	

¹Statistical Significance of F-value
MinMfg = Mining and Manufacturing
GovUtil = Government and Public Utilities
ServNC = Services/ Not Classified

TABLE 6 ACTIONS RESPONDENTS WERE WILLING TO TAKE TO ENSURE LIFETIME UNIVERSAL COVERAGE, BY INDUSTRY AND UNION POSITION (PERCENTAGE DISTRIBUTION)

[Table 6](#) indicates actions the respondents were willing to take to ensure lifetime universal coverage. The only alternative supported by a slim majority of respondents (52 percent) was to pay more taxes. This response is inconsistent with that of the American public who are not inclined to support health care reform if it results in significantly higher taxes. However, the response is consistent with recent data indicating public acceptance of some tax increase to secure access to essential health services.¹⁸ None of the other personal constraints suggested garnered support from more than one-quarter of the respondents. Again, this position is consistent with the AFL-CIO goal to guarantee all Americans the right to health care through a national program.⁸ The most significant difference was that respondents in the service sector were more willing than others to accept an assigned physician.

As previously noted in [Table 5](#), a preference was indicated for sin taxes over a general tax. Recently, labor union health care funds have filed suit against cigarette makers in 21 states, "claiming the tobacco industry has been targeting blue-collar workers for decades, resulting in billions of dollars in health care costs shared by workers and their employers."^{20(p. 6)} There was also a desire on the part of many respondents to ensure that any program for universal coverage allows the possibility of improving basic health care coverage through collective bargaining. In addition, respondents felt that health care reform proposals should be easily understood by the rank-and-file members.

[Table 6](#) indicates 52 percent of our labor union respondents are willing to pay higher taxes to ensure lifetime coverage for all citizens. However, only 47 percent of all Americans are willing to pay higher taxes to achieve the same end.²¹ Moreover, a 1996 nationwide telephone survey of 2,003 adults conducted for the Wall Street Journal and NBC News found the public prefers "protecting" Medicare rather than "reforming" it.²² Nearly two-thirds of those polled said they would rather see cuts in other programs than have Medicare benefits reduced or payroll taxes increased. Only 10 percent wanted individual users (i.e., Medicare recipients) to incur higher costs. This is similar to the 8.6 percent of union officials who wanted Medicare recipients to bear a higher cost ([Table 5](#)).

On the other hand, 43 percent of the Americans polled in the Medicare survey were willing to raise beneficiaries' out-of-pocket for premiums and deductibles compared to only 16.2 percent of union leaders. Large pluralities in both surveys favored having health care providers bear the costs of reform. In the Medicare survey, 45 percent favored reducing payments to physicians and hospitals compared to 42.9 percent of union leaders who identified this solution in our survey. In summary, the only difference in attitude between our union sample and the general public is that the public is more willing to accept

higher out-of-pocket premiums and deductibles.

Nevertheless, the majority of Americans prefer the status quo or incremental change rather than sweeping reform. The Kaiser Family Foundation recently surveyed 1,000 voters and found 51 percent wanted to keep taxes and health care spending the same; 30 percent wanted to decrease spending and cut taxes; and only 14 percent wanted to increase government spending and raise taxes.²¹ This survey also found that only 22 percent felt the federal government should be most responsible for paying for health insurance for the uninsured. Comparable percentages for other stakeholders were 20 percent for large corporations, 31 percent for individual users, and 17 percent for state governments. By contrast, our labor union data show a greater emphasis on the federal government (60 percent for sin tax and 37 percent for general tax) and large corporations (59 percent) and less emphasis on individual users (16 percent) as compared to the general public.

Actions	All Respondents	By Industry				By Union Position			
		MinMfg	GovUtil	ServNC	<i>p</i> ¹	Paid Staff	Local Officers	Activists	<i>p</i> ¹
Provided by Federal Government (N=163)									
Yes	71.8	69.4	74.4	90.0	n.s.	80.0	40.0	100.0	n.s.
No	28.2	30.6	25.6	10.0		20.0	60.0	0.0	
Subject for Collective Bargaining (N=143)									
Yes	91.6	92.0	93.3	78.0	n.s.	100.0	100.0	100.0	n.s.
No	8.4	8.0	6.7	22.0		0.0	0.0	0.0	

¹Statistical Significance of F-value
MinMfg = Mining and Manufacturing
GovUtil = Government and Public Utilities
ServNC = Services/Not Classified

TABLE 7 PERCENTAGE OF RESPONDENTS WHO FEEL EMPLOYEE INSURANCE SHOULD BE PROVIDED BY THE FEDERAL GOVERNMENT AND BE A SUBJECT FOR COLLECTIVE BARGAINING BETWEEN UNION AND MANAGEMENT, BY INDUSTRY AND UNION POSITION

[Table 7](#) shows the percentage of respondents who believe employee health insurance should be provided by the federal government, or be subject to collective bargaining between unions and management. Since these were separate questions, the responses are not mutually exclusive. A respondent could be in favor of both federal government provisions of health insurance as well as allowing collective bargaining for supplemental coverage.

Indeed, the majority do favor both federal government provision of basic health insurance supplemented by the opportunity for labor and management to negotiate benefits beyond the minimum. While 77 percent favored a federal program, 92 percent supported health benefits as a topic for collective bargaining. The bottom line for most respondents is that while they want the federal government to provide a basic health insurance package for all citizens, they wish to maintain opportunities for labor and management to supplement this package through collective bargaining.

A substantial constituency within the labor movement has positive reasons to prefer a multiple-payer approach. Employer-based health insurance would then continue to be a negotiating subject for labor unions. This is important because health and welfare funds represent the most tangible link between the unions and their rank-and-file membership.¹⁴ This is especially true given the stagnant or falling real wages that organized labor has often been compelled to accept.²³ Indeed, limited wage increases may have been seen as an acceptable trade-off in order to preserve or improve health benefits.²⁴

DISCUSSION

American labor union leaders were in the forefront of the failed effort to reform health care in 1994. The major reason for the reform initiative's failure was the ambivalence of most Americans including union members. While most feel reform of the health system is needed, there is a relatively low base of specific knowledge and little agreement concerning the reforms needed.¹⁹ For example, it has been stated that "the manifest linkage to union collective bargaining strategies may come to be seen as More of a handicap and as less a virtue by union leadership."^{15(p.143)} Historical commitments to a system of collective bargaining in which fringe benefits are a fundamental component has restricted the range of political options considered by organized labor.

To craft a viable set of reforms, data are needed on the relative acceptability of various specific reforms to the key stakeholders in the system. Without such research, political roadblocks are more likely, and the possibility of crafting compromise legislation that can pass both houses of Congress and avoid a presidential veto is diminished. Organized labor is one of the key stakeholders. This article is the first to examine the attitudes of the wide range of labor union officials in Alabama, or elsewhere, toward various aspects of our current and future health care system.

There were some response differences between the paid staff when compared to the local officers and union activists. In general, the paid staff provided more sophisticated answers, perhaps reflecting a broader knowledge of health care issues. It is one of the paid staff's duties to gather information on health care and how union employees compare with non-unionized workers. Therefore, it is not surprising that they have a more positive view of their own health benefits. Furthermore, it is also logical that they would be more cost conscious compared to other local union officials who may be less knowledgeable. There were few differences in respondents with the exception of those respondents in the manufacturing industry to be more satisfied with their health coverage than those in service industries.

Our data indicate that most local labor union officials are satisfied with their own health care coverage and do not want to see their benefits reduced. However, they are very dissatisfied with the cost of insurance. Based on their written comments, the respondents want some form of national reform despite satisfaction with their current coverage, for five reasons: (1) the belief that the high costs of coverage is due to provider's cost-shifting of the uninsured's expenses to the respondents' plan; (2) the rising proportions of the nation's workers who are uninsured ²⁵; (3) their inability to raise wages and achieve other improvements through collective bargaining in light of the employers' health care burden; (4) the continuing shift of health costs from employers to employees ²⁶; and (5) the inability of collective bargaining to solve these problems. All of these factors have pushed labor union officials to support health care reform.

Union officials, like the American public, view others as the cause of health cost problems. The most important of these "others" are hospitals, physicians, insurance companies, and lawyers. Each of these stakeholders operates outside the arena of traditional collective bargaining. These data also illustrate the difficulty facing any health care reform proposal. Similar to most Americans, our labor sample does not see itself as a cause of the cost problem, and are reluctant to inconvenience themselves, restrict their access, or modify their behavior to contribute to a solution.¹⁹ Our respondents strongly favor caps on the reimbursement of providers (including hospitals and physicians), administrative expenses, and premiums for health and malpractice insurance.

When our respondents were asked who should bear the additional costs to reform health care, the

theme of recommending that others change their behavior continued. Most respondents want both the federal government and large corporations to bear the additional costs, and feel the sacrifices necessary to reform the system should be borne by the health industry itself (particularly through price controls on providers). Obviously, these solutions are far less acceptable to conservative politicians, large corporations, and health care providers.

Finally, our data indicate the only action the majority of respondents were willing to take to ensure lifetime universal coverage was to pay more taxes in the form of sin taxes. They are similar to the American public in this respect.²⁷ We did not ask how much in additional taxes would be acceptable, but previous research on this topic indicates the average American is willing to pay very little in additional taxes for this purpose.¹⁹ These respondents are probably quite similar in that respect. The amount of additional taxes they are willing to pay would probably not come close to providing the benefits they would like the government to provide. Blendon and Donelan ¹⁹ found that their respondents were unwilling to pay an extra \$30 per month to reform the system. Similarly, Jacobs and Shapiro ¹⁸ reported survey results in which 20 percent or less of the respondents were willing to pay greater than a \$200-a-year tax increase for national health insurance. Our respondents also wanted to ensure that future health care reform would provide for collective bargaining to supplement whatever basic coverage is provided.

Insofar as this study of the attitudes of Alabama union officials can be generalized, it indicates the dilemma facing all proposals for health care reform. Proposals that provide the breadth and level of benefits desired by the majority of respondents have higher costs that need to be absorbed by stakeholders who are unwilling to do so. Another approach that reduces benefits is acceptable to the employers but unacceptable to workers. It appears an incremental approach to health care reform, focusing initially on only those attributes supported by both corporations and the public, will be the only viable reform strategy.

Clearly, unions are already adapting in a couple of ways. First, and perhaps most promising, is a closer partnership with employers similar to the situation at Saturn. Second, unions have displayed a willingness to accept health insurance that provides incentives for workers to moderate their consumption of services.³⁻⁵ Union leaders understand that if insurance costs remain constant, negotiations can center on increasing real wages.

By using a collaborative, rather than confrontational, approach it is possible for unions and employers to involve other major health care stakeholders regarding the details of possible health care reform proposals. While health care reform is often thought of in absolutist terms (i.e., managed competition vs. rate regulation vs. employer mandates vs. medical savings accounts), the transition will require several years and require more flexible solutions combining elements from several proposals.²⁸

Future research should address the problems, concerns, and acceptability of various proposals as perceived by such stakeholders as large corporations, small companies, labor union officials, labor union members, nonunion employees in various occupational categories, public officials, and the general public. A breakdown of respondents by industry, region, urban vs. rural area, degree of managed care penetration in the region, and other demographic factors should be gathered and analyzed.

Such research should precede proposals for significant reform and should be reflected in their design. While the present article addresses attitudes of labor union officials, future research could also probe the attitudes of union members who do not hold a union office or position. Future attitude surveys

should assess the response to the specifics of a wide variety of health reform proposals before they are introduced in Congress. While incorporating acceptable components and postponing unacceptable components does not guarantee approval, it would certainly enhance the probability of passage.

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