Union Activity in Hospitals: Past, Present, and Future

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Between 1970 and 1980, the percentage of hospitals with one or more collective bargaining contracts increased from 15.7 percent to 27.4 percent. A substantial amount of variation exists in the extent of unionism on the basis of hospital ownership, bed size, and location. Employees are more likely to organize when hospitals in the State are regulated by a mandatory rate-setting program. Unions raise hospital employee's wages—a modal estimate for RNs is about 6 percent; the corresponding figure for nonprofessional employees is about 10 percent. Growth of union activity in hospitals has generally not been a major contributor to hospital wage inflation, and less than 10 percent of the increase in real (relative to the Consumer Price Index) spending for hospital care that occurred during the 1970s can be attributed to union growth. We project that between 45 and 50 percent of all hospitals will have at least one union by 1990.

Introduction

Several factors have contributed to the growing interest of social scientists in union activity in hospitals. The first is the continued high cost of hospital care. By 1980, hospitals had become a $100 billion industry. Hospitals alone accounted for over 4 percent of the nation's Gross National Product (Gibson and Waldo, 1981). Second, although the proportion of total hospital expense attributable to labor is declining and will probably continue to do so in the future, labor's share was still nearly three-fifths of the total in 1980 (American Hospital Association, 1981). Third, Congress amended the National Labor Relations Act (NLRA) in 1974 to include coverage of private (i.e., nongovernmental) nonprofit hospital employees. Private nonprofit hospitals are the largest segment of the hospital industry by far. The amendments facilitated growth of collective bargaining in more than half the hospitals in the United States which previously had not been covered by the NLRA. Fourth, empirical studies show that unionization raises hospital costs (Salkever, 1982; Sloan and Steinwald, 1980b; Sloan and Adamache, 1981; and Cain, *et al.*, 1981).

In spite of the growing interest in union activity in hospitals, a number of questions remain unanswered. First, what have been the trends in unionization in the hospital sector? Although a number of studies have dealt with hospital unions,[1] very little information on national trends has been available, especially for the post-1974 period. Second, what factors account for differences in union activity in a cross-section of hospitals as well as over time? Third, what is the overall impact of unions on hospital wages and costs? Finally, in view of what is known, what can be said about the future growth of unions and hospital costs?

This study presents an overview of union activity in the hospital industry with particular attention to the period following the 1974 amendments to the NLRA. The next section briefly summarizes the development of Federal legislation and its relationship to the hospital sector. Section III presents data on union trends from two sources: periodic surveys by the American Hospital Association (AHA) on the presence of at least one collective bargaining agreement in hospitals, and the National Labor Relations Board's (NLRB) monthly election reports. Evidence of impacts of hospital unions on hospital wages and costs is briefly summarized in Section IV. Finally, findings on union trends and their cost consequences provide the basis for projecting in Section V union developments likely to occur during the 1980s.

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[1] See, for example, Delaney (1980, 1981), Dworkin, *et al.* (1980), Frenzen (1978), and Tanner, *et al.* (1979).

Background

The NLRA, popularly known as the Wagner Act, is the major Federal statute governing labor relations in the U.S. Enacted in 1935, the NLRA provides the protective Federal framework for workers to organize, form unions, and bargain collectively. The law initially included all private hospitals, both nonprofit and for-profit. In 1947, however, the Taft-Hartley Amendments exempted private nonprofit hospitals from NLRA coverage on grounds that the hospital industry did not constitute interstate commerce and that, as charitable institutions, nonprofit hospitals should not be included under the NLRA umbrella (Pointer and Metzger, 1975). For-profit hospitals continued to be covered under the NLRA but in practice the NLRB did not begin to exert jurisdiction over the for-profit hospitals until the late 1960s.[2]

Both Federal and non-federal government hospitals were also excluded from the NLRA in 1947. In 1962, however, President Kennedy signed Executive Order 10988 establishing union election procedures for collective bargaining in Federal hospitals. In return for the right to organize, Federal hospital bargaining units established under the jurisdiction of E.O. 10988 must agree not to strike. Labor relations in non-federal government hospitals have never been governed by Federal authority. Instead collective bargaining in these hospitals has been under the purview of State laws in some States and by State attorney's general offices and other legal authorities in the remaining States (Dworkin, *et al.*, 1980).

When private nonprofit hospitals were excluded from the NLRA in 1947, States were free to fill the legal vacuum. Most States, however, opted not to take a position; by 1974 only 12 States had enacted laws to regulate hospital union activity.[3] Partly because of low prevailing wages and high employee turnover in the hospital industry, Congress further amended the NLRA in 1974 (PL 93-360) (Tanner, *et al.*, 1981). These amendments brought private nonprofit hospitals back under the jurisdiction of the NLRA and, by doing so, granted over 1.5 million hospital workers NLRA protection in their organizing and bargaining activities.

Union Growth

Hospital Union Growth in the 1960s

Table 1 shows percentages of U.S. hospitals by hospital ownership class with at least one collective bargaining agreement in 1961, 1967, and 1970. Despite the legal vacuum created by Taft-Hartley, unionization activity was substantial during the 1960s. The percentage of hospitals with at least one signed collective bargaining agreement increased in each type of ownership category, particularly during the latter part

[2]These cases established NLRB jurisdiction over the for-profits: Butte Medical Properties, 168 NLRB No. 52 (1967); University Nursing Home, Inc., 168 NLRB No. 183 (1967).

[3]These states are Minnesota, New York, Pennsylvania, Wisconsin, Massachusetts, Utah, Colorado, Michigan, Connecticut, Oregon, Montana, and Hawaii. For a detailed discussion of these state provisions, see Tanner, *et al.* (1979).

TABLE 1
Hospitals with One or More Collective Bargaining Contracts, by Hospital Ownership, 1961-70

Hospital Ownership	1961 Number of Registered Hospitals	1961 Percentage of Hospitals with Contracts[1]	1967 Number of Registered Hospitals	1967 Percentage of Hospitals with Contracts[1]	1967 Annual Growth Rate[2] 1961-67	1970 Number of Registered Hospitals	1970 Percentage of Hospitals with Contracts	1970 Annual Growth Rate[2] 1967-70	Annual Growth Rate[2] 1961-70
All hospitals	6,923	3.2	7,172	8.2	15.7	7,123	15.7	21.7	17.7
Federal	437	0.0	416	22.6	[3]	408	51.9	27.7	[3]
Non-federal	6,486	3.4	6,756	7.3	12.7	6,715	13.3	20.0	15.2
Nongovernment nonprofit	3,588	4.6	3,692	8.7	10.6	3,600	13.2	13.9	11.7
For-profit	973	5.4	923	6.1	2.0	858	10.0	16.5	6.8
State and local	1,925	1.1	2,141	5.6	27.1	2,257	14.9	32.6	29.0

Source: American Hospital Association (1972)

[1]The data source reported percentage figures with survey respondents in the numerator and the sampling universe in the denominator. Because 7-10 percent of hospitals surveyed did not respond, percentages were adjusted for each hospital ownership class on the basis of survey responses for 1970.

[2]Compounded continuously.

[3]Growth rate cannot be computed.

of the decade. Largely because of E.O. 10988, Federal hospitals showed the greatest growth rate of all. No collective bargaining agreements existed in Federal hospitals in 1961; by 1970 over half of such hospitals had at least one signed agreement.

Union growth rates were modest in non-federal hospitals but still were substantial. State and local government hospitals had the lowest union penetration of the three non-federal hospital types in 1961. By 1970, nearly 15 percent had union contracts, making State and local hospitals the most unionized of the three non-federal hospital types. By contrast, for-profit hospitals had the lowest union growth rate over the entire decade. Nevertheless, union growth in for-profit hospitals was greater during 1967-70 than earlier in the decade which probably reflects the fact that the NLRB did not exert jurisdiction over the for-profit hospitals until the late 1960s. Private nonprofit hospitals, the largest hospital ownership class, showed steady growth in union penetration over the 1960s, moving from 4.6 percent to 13.2 percent with collective bargaining agreements.

Data on which Table 1 is based do not reveal the extent of unionization within hospitals, only whether one or more union contracts existed. Unfortunately, there is little longitudinal evidence available on the proportions of hospital employees unionized. Reports of Industry Wage Surveys by the Bureau of Labor Statistics (BLS) have included estimates of the percentage of unionized hospital employees every third year since 1966, but these data are only for selected occupational groups in selected cities. Although the areas covered by BLS have remained fairly consistent, the employee categories have not. Nevertheless, one may infer from BLS information that the percentage of hospital employees covered by collective bargaining contracts has generally increased. In 1966, for example, one-eighth of full-time professional nurses employed by State and local government hospitals worked in hospitals in which a majority of the professional nursing staff was unionized. The corresponding percentage for private hospitals was much lower—5 percent (U.S. Bureau of Labor Statistics, 1967). By 1969 these figures had increased to over one-fifth in State-local government hospitals and between 5 and 9 percent in private hospitals (U.S. Bureau of Labor Statistics, 1971).

Hospital Union Growth in the 1970s

Table 2 shows the percentage of U.S. hospitals with at least one collective bargaining agreement and growth rates in this percentage during the 1970s. These data come from six surveys conducted by the American Hospital Association. Some of the intertemporal variation is due to slight sample changes from year to year.[4] As seen in the table, union growth generally continued during the 1970s. Between 1970 and 1980, the percentage of all hospitals with collective bargaining contracts increased from 15.7 to 27.4 percent which translates into a compound annual growth rate of 5.6 percent. It is clear from Table 2, however, that the rate of union growth declined markedly throughout most of the 1970s and only since 1977 has it begun to increase. Even considering the increase between 1977 and 1980, growth in union coverage was below the 5.6 percent annual growth rate for the 1970s as a whole. The highest growth rate in the 1970s was for 1970-73 which was only slightly more than one-third of the rate for the preceding three-year period (see Table 1).

Table 2 indicates a slight rise in union growth in nongovernmental nonprofit hospitals after the 1974 amendments as reported in some past studies of hospital unionization (Frenzen, 1978; Rosmann, 1975). Growth rates during 1973-75 were higher in religious and other voluntary hospitals than the corresponding rates for 1970-73. Nongovernmental nonprofit hospital union growth rates during the 1960s, however, were more than double the growth rates in contracts around the time the 1974 amendments were enacted. It appears that, despite the legislative encouragement, these amendments followed the major portion of union growth and had only a small impact around the period of enactment. During 1977-80, growth of collective bargaining in nonprofit hospitals again fell below average growth for U.S. hospitals as a whole.

The number of reporting Federal hospitals declined over the 1970s but the proportion with at least one collective bargaining contract grew to a high of 86.1 percent in 1980. By contrast, non-federal government hospitals had the second highest percentage with collective bargaining in 1980 (28.8 percent).

Past studies have shown that collective bargaining is less likely to arise in religious than in nonprofit hospitals without a religious affiliation (Dworkin *et al.*, 1980; Delaney, 1980). Employees in religious hospitals appear to identify more closely with the hospital than employees of other hospitals. Table 2 confirms this pattern. Through the first half of the 1970s, religious hospitals had the lowest proportion of collective bargaining agreements of any major hospital category. Religious hospitals had a higher rate of union growth than other private hospitals during the 1970s; however, and by 1980 the percentage of hospitals with at least one signed agreement was lowest for the for-profit hospitals. Nevertheless, as of 1980, the percentage of religious hospitals with collective bargaining agreements remained nine percentage points below the corresponding percentage for their nonreligious nonprofit counterparts.

[4]All AHA registered hospitals were surveyed in each year but because of nonresponse (about 10 percent on average) and changing composition of the industry from openings, closures, and mergers, the 6 hospital samples are not identical.

TABLE 2
Hospitals with One or More Collective Bargaining Contracts, by Hospital Ownership, 1970-80

Hospital Ownership	1970[1] No. of Reporting Hospitals	1970[1] Percentage of Hospitals with Contracts	1973 No. of Reporting Hospitals	1973 Percentage of Hospitals with Contracts	1973 Annual Growth Rate[2] 1970-73	1975 No. of Reporting Hospitals	1975 Percentage of Hospitals with Contracts	1975 Annual Growth Rate[2] 1973-75	1976 No. of Reporting Hospitals	1976 Percentage of Hospitals with Contracts	1976 Annual Growth Rate[2] 1975-76	1977 No. of Reporting Hospitals	1977 Percentage of Hospitals with Contracts	1977 Annual Growth Rate[2] 1976-77	1980 No. of Reporting Hospitals	1980 Percentage of Hospitals with Contracts	1980 Annual Growth Rate[2] 1977-80	1980 Annual Growth Rate[2] 1970-80
All hospitals	6,417	15.7	6,026	19.9	7.9	6,174	22.8	6.8	5,691	23.3	2.2	5,762	23.5	0.9	4,582	27.4	5.1	5.6
Federal	393	51.9	371	67.7	8.9	374	77.0	6.4	319	82.5	6.9	303	77.2	– 6.6	258	86.1	3.6	5.1
Non-federal	6,024	13.3	5,655	16.7	7.6	5,800	19.2	7.0	5,372	19.8	3.1	5,459	20.6	4.0	4,324	23.8	4.8	5.8
Nongovernment nonprofit	3,330	13.0	3,136	15.7	6.3	3,185	18.6	8.5	3,066	19.7	5.7	3,049	20.4	3.5	2,522	23.2	4.3	5.8
Religious	767	7.8	722	10.3	9.3	698	12.8	10.9	677	13.7	6.8	659	13.7	0.0	557	16.3	5.8	7.4
Other nongovernment nonprofit	2,563	14.6	2,414	17.3	5.7	2,487	20.2	7.7	2,389	21.4	5.8	2,390	22.2	3.7	1,965	25.2	4.2	5.5
For-profit	648	10.0	573	11.7	5.2	637	13.7	7.9	550	11.1	– 21.0	579	11.7	5.3	427	11.5	– 0.6	1.4
State and local	2,046	14.9	1,946	19.9	9.6	1,978	22.0	5.0	1,756	22.8	3.6	1,831	23.7	7.4	1,375	28.8	6.5	6.6

Source: AHA Annual Survey, various years.

[1]1970 figures in Table 2 differ from those in Table 1 because those in Table 1 represent estimates for all AHA hospitals while those in Table 2 are for reporting hospitals only.

[2]Compounded continuously.

Table 3 indicates a clear relationship between hospital size and propensity to unionize, a finding also documented in past studies (American Hospital Association, 1972; Frenzen, 1978). Larger hospitals have more potential bargaining units and more employees per unit, giving organizing efforts a potentially larger payoff per dollar of organizing expense (Frenzen, 1978). The association between collective bargaining and hospital bed size indicates that per-hospital statistics tend to understate the unionization trend when one considers that the number of patients, patient days, and other dimensions of hospital output are also closely related to hospital size.

Table 3 also indicates that hospitals in urban locations are more likely to have collective bargaining agreements than rural hospitals, probably reflecting an association between urbanization and hospital size. In addition, union penetration throughout the 1970s has been greatest in the northeastern U.S. and on the west coast—areas that have historically been pro-union. By 1977, over 40 percent of hospitals in these areas had at least one signed collective bargaining agreement; whereas, in the south this percentage had not yet reached double figures.

NLRB Election Results—1974-1979

Tables 4 and 5 report results from the NLRB's monthly election reports for August 1974 through December 1979, which is the period immediately following the implementation of the 1974 amendments. Both tables present data on elections and election outcomes not assembled heretofore; they include only nongovernmental hospitals because government hospitals are not covered by the NLRA. Observational units are the hospital in Table 4 and the election in Table 5. A total of 1,025 elections in 556 hospitals are reported in the tables.

The first row on Table 4 indicates that 16.2 percent of nongovernmental hospitals had elections during the period August 1974 through December 1979, and unions won 48.6 percent of these elections. Nearly 70 percent of the elections occurred in three of the nine U.S. Census Divisions—Mid Atlantic, East North Central, and Pacific. Percentages of hospitals having elections were highest in these three and the New England Census Division. Differences in union victory rates across Census Divisions are statistically significant at the 5 percent level.

Religious and nonreligious nonprofit hospitals were equally likely to have union elections, but elections were much rarer in for-profit hospitals. The union victory rate, however, was highest in the for-profit hospitals and lowest in religious hospitals. The election rate differences may reflect bed size differences among hospital ownership classes. The for-profit hospitals tend to be relatively small and election rates increase monotonically with bed size. For reasons stated above, larger hospitals present a more attractive target for union organizing efforts than smaller ones.

The lower victory rate for religious hospitals is consistent with past evidence (Delaney, 1980). Employees in religious hospitals appear to have greater loyalty to the hospital than employees in other types of hospitals. In many cases they may actually be members of the religious denomination with which the hospital is affiliated. Although the high victory rate of for-profit hospitals is also consistent with other studies (Delaney, 1980), reasons for this pattern are not clear.

Unions appear to avoid areas (primarily in the south) where the legal and social environment is not receptive to union activity. In states with right-to-work laws, for example, only 4.6 percent of hospitals had union elections and the victory rate was nearly 12 percentage points below the U.S. average.[5] By contrast, states in which the legal environment has traditionally been receptive to union activity—those with laws facilitating collective bargaining in nonprofit hospitals before 1974—had union election rates over twice those of other states (Tanner, *et al.*, 1979), and union victory rates were substantially higher there as well.

Table 5 presents frequency distributions of union elections by union and election characteristics and victory rates for each category defined by the characteristics. The table indicates that nearly one-third of elections were organized by independent employee associations (employees not affiliated with a national union)[6] and the victory rate was highest for this union category—approximately 13 percentage points above the national average. The Service Employees International Union (SEIU) and District 1199 of the Retail, Wholesale, and Department Store Union, respectively, accounted for the next two largest shares of hospital union organizing efforts. The victory rate for SEIU was slightly below the national average and the rate for District 1199 was slightly above it.

[5]There is substantial literature on right-to-work laws, regional variations, and their influence on unionization. On right-to-work laws see, for example, Lumsden and Petersen (1975), Moore and Newman (1975), Warren and Strauss (1979), and Hirsch (1980). On regional variations, see Dunlop (1948), Moore and Newman (1975) and Hirsch (1980).

[6]Independent employee associations include many independent labor organizations not affiliated with the AFL-CIO, but does not include some major independent unions, such as the Teamsters or Communication Workers of America. The American Nurses' Association (ANA), however, is included as an independent. Unfortunately, the NLRB did not distinguish elections in which the ANA was involved until 1977.

TABLE 3
Hospitals with One or More Collective Bargaining Contracts, by Size and Location, 1970-80

Hospital Size and Location	1970		1973			1975			1976			1977			1980			
	No. of Reporting Hospitals	Percentage of Hospitals with Contracts	No. of Reporting Hospitals	Percentage of Hospitals with Contracts	Annual Growth Rate[1] 1970-73	No. of Reporting Hospitals	Percentage of Hospitals with Contracts	Annual Growth Rate[1] 1973-75	No. of Reporting Hospitals	Percentage of Hospitals with Contracts	Annual Growth Rate[1] 1975-76	No. of Reporting Hospitals	Percentage of Hospitals with Contracts	Annual Growth Rate[1] 1976-77	No. of Reporting Hospitals	Percentage of Hospitals with Contracts	Annual Growth Rate[1] 1977-80	Annual Growth Rate[1] 1970-80
Bed size																		
<100	2,910	6.9	2,713	9.3	9.9	2,761	11.8	11.9	2,498	12.3	4.1	2,528	11.8	– 4.1	1,899	15.7	9.5	8.2
100-249	1,861	18.2	1,732	22.9	7.7	1,818	25.6	5.6	1,708	25.4	– 0.8	1,731	26.5	4.2	1,400	29.2	3.2	4.7
250-399	760	21.5	732	26.5	7.0	740	29.9	6.0	706	30.3	1.3	705	31.2	2.9	615	34.6	3.4	4.8
>400	886	34.4	849	41.6	6.3	855	46.3	5.4	779	47.9	3.4	798	47.7	– 0.4	688	49.9	1.5	3.7
Urban/Rural																		
Non-SMSA	2,894	7.8	2,731	11.1	11.8	2,775	12.8	7.1	2,583	14.4	11.8	2,606	14.5	0.7	2,009	18.7	8.5	8.7
SMSA	3,522	22.2	3,295	27.1	6.6	3,399	30.9	6.6	3,108	30.7	– 0.6	3,156	31.0	1.0	2,573	34.2	3.3	4.3
Census Division																		
New England	375	24.0	363	27.3	4.3	361	34.4	11.4	321	33.3	– 3.2	320	40.9	20.6	255	47.1	4.7	6.7
Mid Atlantic	813	26.6	768	40.1	13.7	772	45.7	6.5	693	44.7	– 2.2	687	43.5	– 2.7	555	47.4	2.9	5.8
So. Atlantic	850	8.5	818	10.6	7.4	854	11.6	4.5	816	12.4	6.7	844	11.3	– 9.3	698	15.3	10.1	5.9
E. No. Central	1,053	18.0	986	22.0	6.7	1,010	25.5	7.4	950	27.2	6.5	964	26.8	– 1.5	775	29.6	3.3	5.0
E. So. Central	461	6.3	432	6.9	3.0	447	7.2	2.1	421	7.6	5.4	415	8.7	13.5	333	11.7	9.9	6.2
W. No. Central	825	12.0	766	13.3	3.4	811	16.5	10.8	771	18.3	10.4	767	18.1	– 1.1	625	22.1	6.7	6.1
W. So. Central	807	4.2	761	5.3	7.8	783	5.8	4.5	682	6.0	3.4	700	6.1	1.7	516	9.9	16.1	8.6
Mountain	397	9.1	385	11.4	7.5	378	14.8	13.1	368	15.0	1.3	375	16.3	8.3	281	17.8	2.9	6.7
Pacific	839	28.8	747	36.1	7.5	758	40.5	5.8	669	42.2	5.1	690	42.6	0.9	544	47.2	3.4	4.9

Source: AHA Annual Surveys, various years.
[1]Compounded continuously.

TABLE 4
NLRB Elections and Outcomes in Nongovernmental Hospitals by Selected Hospital and Area Characteristics, August 1974-December 1979

	Number of Hospitals with Elections	Percent of Hospitals with Elections[1]	Number of Elections	Union Victories as a Percent of Elections
All hospitals	556	16.2	1,025	48.6
Census Division				
New England	58	24.9	106	57.6
Mid Atlantic	156	31.4	310	52.6
So. Atlantic	33	7.5	55	41.8
E. No. Central	121	20.1	221	41.2
E. So. Central	17	8.2	23	56.5
W. No. Central	27	6.7	51	49.0
W. So. Central	13	3.4	18	22.2
Mountain	25	12.5	39	51.3
Pacific	106	23.5	202	48.5
Ownership				
Nonprofit-religious	115	17.7	176	36.4
Nonprofit-nonreligious	395	17.6	756	50.4
For-profit	46	8.6	93	57.0
Bed size				
<100	118	7.8	204	52.9
100-249	207	18.5	387	48.1
250-399	121	25.8	198	43.4
>400	110	33.0	236	50.0
SMSA size				
Non-SMSA	153	11.0	269	49.4
<100,000	6	13.0	11	72.7
100,000-250,000	52	20.4	95	50.5
250,000-500,000	52	16.1	93	41.9
500,000-1,000,000	50	16.5	90	34.4
1,000,000-2,500,000	98	18.3	155	40.0
>2,500,000	145	25.4	312	56.7
Right-to-work[2]				
No	509	21.4	950	49.9
Yes	47	4.6	75	32.0
Worker protection[2]				
No	268	11.2	453	38.9
Yes	288	27.9	572	56.3

Source: NLRB Election Reports, August 1974-December 1979.
[1]Based on the census of AHA registered hospitals in 1974.
[2]Differences in victory rates are significant at the .05 level.

TABLE 5
NLRB Elections and Outcomes in Nongovernmental Hospitals by Selected Union and Election Characteristics, August 1974-December 1979

	Number of Elections	Percent of Elections[1]	Number of Union Victories	Union Victories as a Percent of Elections
All hospitals	1,025	100.0	498	48.6
Employee organization[2]				
Independent union	313	30.5	193	61.7
Service employees	220	21.5	103	46.8
District 1199	128	12.5	64	50.0
Teamsters	68	6.6	21	30.9
Operating engineers	51	5.0	24	47.1
State, county, and municipal employees	45	4.4	17	37.8
Retail clerks	40	3.9	13	32.5
Laborers	29	2.8	7	24.1
Communication workers	14	1.4	0	0.0
Office employees int'l.	13	1.3	6	47.2
Guard workers	10	1.0	6	60.0
Others	94	9.2	44	46.8
Type of union[2]				
Industrial	227	22.1	66	29.1
Departmental	39	3.8	27	69.2
Guard	35	3.4	22	62.9
Professional and/or technical	450	43.9	257	57.1
Office, clerical and other white collar	131	12.8	67	51.2
Combined professional and office	18	1.8	6	33.3
All others	125	12.2	53	42.4
Type of election[2]				
Stipulation	597	58.2	293	49.1
Regional director ordered	314	30.6	133	42.4
Board ordered	44	4.3	19	43.2
Consent	70	6.8	53	75.7
Nature of election[2]				
Single-union	886	86.4	419	47.3
Multi-union	139	13.6	79	56.8
Year				
1974[3]	74	7.2	50	67.6
1975	236	23.0	113	47.9
1976	181	17.7	87	48.1
1977	237	23.1	109	46.0
1978	152	14.8	69	45.4
1979	145	14.1	70	48.3

Source: NLRB Election Reports, August 1974-December 1979.
[1]Percentages do not always add to 100.0 due to rounding.
[2]Differences in victory rates are significant at the .05 level.
[3]August - December only.

Unions organized into professional and/or technical units were responsible for almost half the NLRB elections after passage of the 1974 amendments (43.9 percent), nearly double the second highest number of elections by industrial employee organizations (22.1 percent). Variations in victory rates among the different union types shown in Table 5 are substantial, ranging from 29.2 percent for industrial unions to 69.2 percent for unions organizing specific hospital departments such as housekeeping or laundry. The reasons for this pattern are unclear; victory rates were not higher on average for white collar, blue collar, or professional/technical groups.

One element of the union election process that has received little attention is the type of NLRB election held. The NLRB distinguishes between five types of representative elections. Most common are the two kinds of consent elections. In the "agreement for consent" election the regional NLRB director makes the final resolution of any disputes concerning the conduct of the election. In the "stipulation for certification on consent" election, the National Board settles all disputes. The latter, termed "stipulation" in Table 5, is far more common than the former, termed "consent" in the table. Stipulation elections usually require a longer period of time to be resolved if disputes arise. The fact that the National Board is involved may appeal to unions and employers alike on "fairness" grounds. Nevertheless, unions have had a substantially higher victory rate in consent agreement than in stipulation elections, although involvement of the National Board is not necessarily a factor in this difference.

Union elections may also be ordered by the National Board or by regional NLRB directors. A Board-ordered election occurs when there are questions concerning the appropriateness of a bargaining unit or circumstances involving a novel issue—for example, a unique bargaining unit. The regional director may order an election when a disagreement occurs between the bargaining parties, but there are no novel issues or circumstances involved. The final type of election identified by the NLRB is the expedited election. This sometimes occurs when unfair labor practices are involved, and the NLRB may move the election date forward.

As Table 5 indicates, there were no expedited elections in hospitals during the second half of the 1970s. The majority of elections are stipulated, followed by regional director-ordered, Board-ordered, and consent elections, respectively. Although consent elections represent only a small proportion of elections, unions won 75.7 percent of them. By contrast, all other types had win rates of under 50 percent. Prosten (1978) has argued that pre-election time delays are the major reason for the difference in the victory rates. Consent elections occur quickly with 75 percent of all consent elections being completed by the end of the month after the month in which the petition is filed. Nonconsent elections, however, are only 68 percent complete within three calendar months of petition filing.

The vast majority of elections in hospitals involve only one union; multiple union elections, in which two or more unions compete with one another to represent a bargaining unit, occur less than one-sixth as often as single union elections. Nevertheless, multiple union elections have higher victory rates than their single union counterparts. It has been suggested that a multiple union election stimulates employee interest and increases prospects for union victory (Chaison, 1973). Also, unions may compete for those bargaining units offering the highest chance of success.

Finally, Table 5 indicates that there was a short-lived spurt in hospital election activity immediately after the 1974 amendments were enacted. Union victory rates were also highest immediately following the amendments, but victory rates declined soon thereafter and remained below 50 percent for the rest of the decade.

Multivariate Studies of Union Elections

Descriptive information is helpful in understanding the "lay of the land," but to gauge the importance of different variables, multivariate methods are required. Only three studies, all based on NLRB data, have used multivariate techniques to examine factors which influence union activity in hospitals (Delaney, 1981; Becker and Miller, 1981; Becker, 1981). Although they have slightly different specifications, they do concur on a number of points.

In general, all three concluded that characteristics associated with the election process or bargaining unit are generally more influential in their impact on the outcome of the election than variables related to hospital environment and organization. All three studies found that, holding other factors constant, the probability of a union victory is lower with larger size election units and a high voter turnout. Moreover, unions are more likely to win an election if there is an existing union or prior union activity before the election is held. Among environmental and structural variables, the most reliable predictor of election outcome is whether the election takes place in areas where there were state laws protecting the right of nonprofit hospital employees to organize prior to passage of PL 93-360. For-profit and religious hospital ownership each lowered the probability of union success; however, since coefficients on these structural variables were not always statistically significant in the three studies, they should be seen as less reliable predictors of election outcome. Factors showing no influence on the election outcome include: right-to-work legislation, area population density, unemployment, cost-of-living, and hospital teaching status. Hospital bed size had a mixed impact on election outcome.

Becker (1981) analyzed data on U.S. hospitals as well as NLRB data to determine the impact of the independent variables on three dependent variables: (1) the probability of a hospital having a collective bargaining agreement in 1980; (2) the likelihood of an

NLRB election; and (3) the likelihood of a union victory in an NLRB election. In addition to the aforementioned independent variables, Becker also emphasized the role of hospital rate review and third party reimbursement.

Recent empirical studies have found that mandatory hospital rate-setting programs have reduced hospital costs, but only after they have been in place for a number of years (Biles, *et al.*, 1980; Coelen and Sullivan, 1981; and Sloan, 1981). Although the aggregate effect of rate-setting on hospital costs is becoming increasingly clear, the mechanisms through which the cost savings are achieved is not well understood. Adamache and Sloan (1982) concluded that rate-setting reduces earnings of hospital employees, especially at the entry level. But to the extent that such reductions occur, do hospital employees tend to organize in self-defense?

Becker's study provides an answer. He found that mandatory state rate-setting has a major impact on the occurrence and outcome of hospital elections. States with such programs have substantially higher levels of union elections and victories. His estimates imply that the probability of having a collective bargaining agreement is 11 percent higher in states with mandatory rate-setting (when all hospital revenue sources are covered by rate-setting). The probability of an election occurring in these states during 1974-79 was 14 percent greater, and a union victory was 13 percent more likely, than in non-rate-setting states.

It appears that hospitals with a high percentage of patient revenue from Medicaid reimbursement have a significantly larger number of signed collective bargaining contracts. Such hospitals also were more likely on average to have had an election in recent years and the probability of a union victory tended to be higher in such settings. All other things being equal, however, hospitals with higher levels of Blue Cross coverage have had significantly lower numbers of collective bargaining agreements and union victories. Unfortunately, Becker could not determine the reason for these latter patterns. However, even if causality cannot be determined with available data, these results merit considerable interest as a matter of statistical description. To the extent that Medicaid-oriented hospitals are under financial pressure from Medicaid cutbacks, the presence of unions in these hospitals may compound their difficulties.

Effects of Unions On Hospital Wages and Costs

To examine trends in hospital unionization would be somewhat sterile without information on the likely effects of these trends. The simplest and most direct type of effect is elevation of wages and the monetary value of fringe benefits of unionized employees. Potential indirect effects include changes in hospital workforce composition and in worker behavior. Unions typically claim that union-induced wage gains need not mean higher costs since they also boost employee productivity and reduce absenteeism and turnover. In addition to effects on unionized hospitals, unions may have "spillover" or "threat effects" on pay levels in nonunion hospitals. It is beyond the scope of this paper to perform a detailed assessment of direct and indirect effects of unions on hospitals. Instead, we provide a brief review of existing evidence on direct effects on wages and on aggregate effects on hospital costs.

Evidence obtained from studies of the effects of collective bargaining on wages and fringe benefits permit several generalizations. First, a statistically significant positive collective bargaining effect has almost always been obtained from studies in hospital and other areas. Typically, unions have had a smaller effect on professional nurses' and other professionals' wages than for nonprofessional occupations. A modal estimate for RNs is about 6 percent; the corresponding figure for nonprofessionals is about 10 percent.[7] A recent study reported an 8.8 percent increase for hospital occupations as a whole (Sloan and Adamache, 1981); this estimate is consistent with other research on this topic.

Second, collective bargaining affects a hospital employee's pay even when he or she is not a union member. These spillover effects may be either internal or external. An internal spillover occurs when the hospital has a union, but a particular department or occupation is not covered. Past studies imply that internal spillover effects raise compensation by as little as 1 and as much as 8 percent. (Feldman and Scheffler, 1982; Adamache and Sloan, 1982; Becker, 1979). An external spillover occurs when collective bargaining activity in one hospital affects pay levels in a neighboring nonunionized hospital. Measures of external spillovers tend to be imprecise but generally support the view that the latter type of spillover exists (Cain, *et al.*, 1981; Adamache and Sloan, 1982).

Third, strikes and other work stoppages have important consequences for wages; the effects of collective bargaining in hospitals having work stoppages is substantially higher than collective bargaining effects without work stoppages. (Sloan and Steinwald, 1980a; Feldman and Scheffler 1982).[8] Fourth, there is some evidence that the union effect on wages is higher

[7]For RNs, estimates are: 0 to 4 percent—Sloan and Elnicki (1978); 5 to 10 percent—Link and Landon (1976); 6.5 percent—Sloan and Steinwald (1980a); 8 percent—Feldman and Scheffler (1982); 3 percent—Cain, *et al.* (1981); negative 3.4 percent—Feldman, *et al.* (1980); 4 to 11 percent—Adamache and Sloan (1982); 6 percent—Sloan and Adamache (1981). For nonprofessional hospital workers: 4.5 to 8.2 percent—Fottler (1977); 7 percent wages and 8.8 percent fringes—Becker (1981); 11 to 12 percent for secretaries and housekeepers—Feldman and Scheffler (1982); 7 to 16 percent for various nonprofessional occupations—Feldman, *et al.* (1980); 4.9 to 17.6 percent for various nonprofessional occupations—Sloan and Steinwald (1980a); 5.6 percent—Cain, *et al.* (1981); 6 to 17 percent for various nonprofessional occupations—Adamache and Sloan (1982); 5 to 12 percent for various nonprofessional occupations—Sloan and Adamache (1981).

[8]This finding does not apply to RNs in the second study.

when the union has been in place for a number of years (Feldman and Scheffler, 1982). This conclusion applies to RNs as well as nonprofessional hospital employees.

Four studies have assessed the impact of collective bargaining on hospital costs. Using a national data base on individual hospitals spanning 1970 through 1975, Sloan and Steinwald (1980b) found that cost per day and per case are 3.3 and 2.1 percent higher, respectively, in the year after collective bargaining is introduced. In equilibrium, the union-nonunion differences for the two types of average cost measures are 5.7 and 3.7 percent, respectively. If the hospital had a recent history of strike activity, total collective bargaining effects were found to be slightly over twice as large. With a sample of hospitals from Illinois, Minnesota, and Wisconsin, Miller, Becker, and Krinsky (1979) found that, for the single-union hospital, the overall increase in cost per day attributable to collective bargaining is 2 to 4 percent. Using a more complete specification, Salkever (1982) obtained estimates of collective bargaining on cost per case of 5 to 9 percent with a sample of hospitals from Maryland, Massachusetts, Pennsylvania, and New York. He derived separate estimates for the total effects of unions and found that about two-thirds of this is due to factors (unidentified) other than the union effect on wages. Sloan and Adamache (1981), using a national sample of 367 hospitals observed for two years, 1974 and 1977, concluded that cost per adjusted (for outpatient activity) patient day and per adjusted admission was 3.5 and 4.1 percent higher, respectively, in hospitals with a union but with no recent history of strike activity. For hospitals with strikes, corresponding effects were 10.2 and 9.0 percent.

Adding spillover effects to the above estimates, a conservative estimate of the full union effect on real hospital expenditures is about 10 percent. This estimate implies that hospital union growth raised real spending on hospital care by about 5 percent during the 1970s as compared to the 67 percent increase actually observed (Adamache and Sloan, 1982).

The 1980s

The discussion thus far has focused on what is known about past union activity in hospitals. What can be said about the future growth of union activity in hospitals and what implications will this have for hospital costs in the 1980s?

First, from all indications, unions will continue to grow both in number of hospitals with union representation and in the extent of occupational groups covered. Feldman, *et al.* (1980) reviewed evidence on the spread of hospital unionization from its inception in 1919 through 1976. Using two multivariate models, they predicted that by 1990 about 65 percent of all hospitals will have one or more union contracts. Evidence from Table 2 suggests that this estimate may be too high. If hospitals with union contracts are to reach 65 percent by 1990, coverage would have to increase dramatically during the 1980s. That would mean an annual rate of growth of 8.6 percent which is considerably higher than actual growth rates since the 1960s. If union growth in hospitals continues at the annual pace of the 1970s, 5 to 6 percent (a more likely outcome), we can expect that by 1990 only 45 to 50 percent of all hospitals will have at least one collective bargaining agreement.

Second, past evidence indicates that union activity follows certain patterns. To date, elections have been more likely to occur in larger, nonprofit, and urban hospitals located in areas with traditionally strong union support. The probability of a union win, by contrast, is unrelated to hospital size or degree of urbanization but highest in profit-oriented hospitals and areas with a strong union orientation. Independent employee associations apparently enjoy the greatest degree of union election success. Multi-union elections and consent elections also both favor unions' chances of winning.

Future patterns of union elections and victories will, in all likelihood, deviate from these past patterns since unions have probably already organized many of the "easy" hospitals. Future efforts will have to turn to the more difficult hospitals, and this is likely to lower the number of actual elections as well as union success rates. For example, the pending merger between the SEIU and District 1199 unions will facilitate organizing health care workers, especially in the southern states where right-to-work laws have made unionization difficult (*Hospitals*, 1981).

Independent employee associations will probably continue to have a high level of success in union elections. Also, the union trend will continue strong in the white collar professions. Consent elections seem to afford unions the best opportunity of winning. However, consent elections probably will not figure prominently in the 1980s because so few elections are of this type.

Third, unions will continue to raise hospital costs over what they would have been in their absence. Projected growth in the percentage of hospitals with contracts from 27 to 45-50 percent by 1990 would raise real 1990 hospital expenditures by 5 percent over what they would be if union activity remained at its 1980 level. Freeland and Schendler (1981) have projected that real expenditures on hospital services will rise 58 percent between 1979 and 1990. The 5 percent contribution from union growth represents less than one-tenth of their projection. As in the past, the level and growth of hospital collective bargaining will be of minor importance as a source of hospital cost levels and inflation. To understand past and future growth of hospital costs, one should concentrate on such first-order factors as insurance coverage for hospital care, product-enhancing technological change which is partly attributable to insurance, as well as rising real per capita income rather than on collective bargaining.

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