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# PHYSICIAN UNIONIZATION

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by


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# ABSTRACT

Recent changes in health care financing have caused many physicians to feel they are losing autonomy and decision-making power to managed care corporations. One proposed solution is for physicians to form unions. This project examined the prospects of physician unionization to determine whether unionization may benefit the health care industry. It was found that the growth of physician unionization is impeded by existing legislation and that potential revisions of such legislation must take into consideration many valid concerns.

AUTHORSHIP

This project is primarily the result of library research efforts by Daniel Martinelli and Dorian Hunt. While many sections of this project were initially written on an individual basis, repeated revisions required involvement from both partners with regard to all sections.

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# Chapter I : Introduction

As unfortunate as it may seem, there are very few people in this nation who will live their entire lives in excellent health. Everyone from farmers and lawyers to mechanics and dancers will probably require medical help at one time or another. For this reason, medical care and the regulations and behaviors that surround it should be of concern to all.

The health care industry in the United States has changed drastically over the past few decades. Physicians and patients alike are finding themselves forced to cope with a wide variety of fluctuations in procedures and policies. Traditional models will not suffice when attempting to describe this dynamic field.

While the condition of medical care in this nation has always been in a constant state of change, recent years have brought unprecedented levels of uncertainty over various issues. Of major concern are the possible consequences of new methods of physician practice and reimbursement. One of these possible consequences, which is the focus of this project, is physician unionization.

The methods of payment and modes of physician practice in the industry have been the focus of much controversy. More and more consumers in America find themselves switching from traditional third party indemnity insurance plans to the newer managed care systems, which tend to cost less than indemnity insurance plans. However, some feel that this switch often causes patients to lose privileges -- such as choice of physicians and access to the best tests and procedures. Additionally, physicians working under managed care systems find that practicing in this new environment requires them to undergo a great deal of adaptation.

The topics of physician reimbursement and modes of physician practice are a major concern among practicing physicians, many of whom are fearful of losing the financial comfort -- as well as the autonomy -- they have traditionally enjoyed. In an attempt to protect their incomes and professional freedom, many are turning to physicians' unions. Unionization, once in the realm of only blue-collar workers, is now starting to become attractive to professionals in the medical care industry as well.

Although the idea of physician unionization is not a new one, it remains a controversial subject. The majority of physicians are not currently eligible to join unions, due to federal regulations that prevent official unionizational activities by self-employed physicians. The physician unionization movement is unlikely to have any major impact on the health care industry unless these policies are changed. However, many parties oppose such changes. There are fears that physician strikes and potential price collusions could severely damage the workings of the medical care industry.

The purpose of this Interactive Qualifying Project is to identify and examine the many aspects and prospects of physician unionization in order to determine whether physicians' unions are capable of benefiting the health care industry.

A rich history has brought the health care industry to where it is today. Many policies and actions have molded United States health care into a unique form. The background chapter of this report provides a brief introduction to this history in order to familiarize the reader with the factors that have led up to the current state of the U.S. health care industry. This chapter also presents an introduction to the various forms of managed care systems and a discussion of the health care systems of a few foreign countries. In addition, the history of government financed health care in the United States is covered. Also, the influential American Medical Association is examined. Finally, the background chapter offers a discussion of the American labor movement and its relevance to the physician unionization movement.

Chapter III describes the procedure used for the project. The information contained in this report came from a combination of books, medical journals, and online resources. The procedure for this project was fairly straightforward, consisting of alternating phases of research and writing, which are described in this chapter.

The results of the project are outlined and analyzed in chapter four. The focus of this results and analysis chapter is on the current activities of physicians' unions and the various opinions concerning the

movement. The results of the actions of existing physician unions, as well general trends in the movement itself, are addressed. Many news sources are providing coverage of physician unionization activities as they occur. It was necessary to stay updated on all recent developments with regard to this topic, since the physician unionization movement itself is still in its infancy in the U.S.

The final chapter contains conclusions based on the data discussed in the results chapter. It discusses the likely direction that the physician unionization movement in the U.S. will take in the coming years, and how the changing health care environment can be embraced in a positive fashion. Recommended courses of action are presented, which should be considered by the major participants in the field. Hopefully, this project will help to guide the actions of physicians, managed care organizations and government authorities, as well as consumers.

In this report, predictions are made on both the potential benefits and potential disadvantages of the physician unionization movement. There are sure to be an abundance of economic, educational, and social effects resulting from this new trend. Based on a multiple sources of available information, conclusions have been drawn concerning the advisability of unionization for United States physicians.

The analyses and conclusions in the coming chapters provide a valuable resource to those hoping to understand the various complexities of the physician unionization movement. The goal is to help citizens form educated opinions with regard to the state of the American health care industry and the possible positive and negative effects that could come from physician unionization. An informed public is the primary prerequisite for a wise and beneficial national health policy.

# Chapter II: Background

This chapter provides the historical and economic background for this project. The idea of physician unionization has come as the result of many years of history -- and many problems and unanswered questions in the realm of medicine. Although physician unions are not intended as a solution to all of the problems currently facing the medical community in the United States, an understanding of these problems and how they came to be helps to foster a greater understanding of the topic.

The health care industry has always been difficult to examine. However, health care plays such an important role in the preservation of life that many people could not imagine living without it. Unlike many other necessities, medical care can be very expensive and difficult to obtain. But it does not follow standard market behaviors. In addition, the growth of the medical industry has prompted the birth and expansion of the now gigantic health care insurance industry.

The health care industry in the United States changed greatly during the 20$^{th}$ century. Not all of these changes have been due to scientific advances. Financial considerations have had a great impact on the state of the industry. Traditional indemnity insurance plans have now been paired with -- and replaced by -- governmentally subsidized care and competitive managed care organizations, both for-profit and not-for-profit. The rise in power of managed care organizations, along with increased government spending in health care, is creating new issues for physicians and patients. The first section of this chapter gives a short history of American health care and health care financing.

The growth in the size of and power of managed care corporations has led to the corporatization of medicine in the United States. While there are many different species of managed care organizations, each with its own acronym, they exhibit many similar behaviors. There are allegations that the activities of

managed care organizations are compromising patient health and physician autonomy. This chapter examines the various forms of managed care and the impact of such organizations.

The governments of many nations have taken medical care matters into their own hands. The United Kingdom, Germany, and Canada, for example, all have some form of national health coverage provided by their respective governments. Such coverage, and its influence on the American health care system, are important topics of this chapter.

Although the United States government does not fully finance its citizens' health care, it does provide programs to assist elderly and low-income patients. Spending on health programs such as Medicare and Medicaid has seen much growth over the past thirty years. While many feel that this growth in spending must be halted, some feel that government must continue to actively participate in the medical care industry. This chapter examines the history and the growing problems with the Medicare and Medicaid systems.

In 1999, the American Medical Association (AMA) voted to create a physician bargaining unit. Allegations that some managed care insurers are causing problems for patients as well as physicians played a crucial role in the AMA's decision to support unionization. For example, there exists a fear that managed care restrictions on physician autonomy can potentially decrease the quality of care that is delivered, harming patients. Therefore, in addition to protecting the incomes and autonomy of physicians, the AMA believes that in some cases, collective bargaining units are a necessary tool in protecting the interests of patients. The history of this influential organization is outlined in this chapter. Throughout the 20th century, the AMA had a great impact on the course of the medical industry, and it will surely continue to do so in the 21st.

There was a time in the past when unionization was limited to the realm of 'blue collar' laborers. Unionization was considered a necessary step in ensuring that the rights of laborers were not neglected in the quest for industrial profits. Organizations like the Knights of Labor and the American Federation of Labor changed the face of industry during the late 19th and early 20th centuries. However, until recently, it was never anticipated that those holding the title of physician would ever have to resort to forming unions. As unlikely as it may seem, there are many parallels between today's physician unionization movement

and the early American labor movement. This chapter examines the history and development of the American labor movement.

Also important in the examination of physician unionization is the development of labor legislation in the US. Legislation has the ability to either facilitate or cripple physician unionization activities. Labor legislation is important to the development of the physician unionization because it inhibits the ability of many physicians to unionize. Labor laws such as the National Labor Relations Act and its amendment the Taft-Hartley Act define the rules of behavior for unions and employers.

The information in this chapter forms the foundation of knowledge necessary for a study of the physician unionization movement. An understanding of this elementary knowledge will help to provide proper context for understanding this movement's implications for the future of American medicine.

## 2.1 History of Health Care Financing in the U.S.

In the early 20th century, health care financing was relatively simple. For the most part, physicians provided their patients with the care they needed, and their services were paid for directly by the patient. This was possible because today's expensive therapies did not exist, and the care that could be provided was usually affordable to the average person. Thus, the foundation for the traditional patient-physician relationship was provided.

However, the health care system was to change significantly in the years to come. As expensive technologies became available, it became increasingly difficult to pay for health care in the traditional way. In order to afford quality health care today, it is all but essential to have some form of insurance. This change was brought about by a number of different events in the 1900's.

When the prosperous 1920's gave way to the Great Depression of the 1930's, hospitals and physicians were troubled by patients who were unable to pay their bills. All of a sudden, people could no longer afford to pay for their basic health care needs. This prompted lawmakers to provide new legislation that allowed for the creation of non-profit health insurance plans, leading to the establishment of the Blue Cross hospital insurance and Blue Shield physician insurance organizations. These early insurance plans were provider-oriented, meaning that they did not interfere with medical decisions -- which were left

entirely up to physicians. At that time, a fee-for-service physician reimbursement system was the standard (Fogoros, 2). In this system, a patient would receive care from the physician or hospital of his/her choice, and pay a flat fee for those services. The rest of the expense was covered by the insurance company. For many years, this method of payment -- called indemnity insurance -- remained the dominant method of physician and hospital reimbursement.

During and after the Second World War, employers began to offer their workers health insurance in place of wage increases, since wage increases had been limited by the government during the war. In addition, health insurance benefits are not taxed by the government. This arrangement was pleasing to the workers, who liked the security that health insurance coverage offered. It wasn't long before labor unions began to demand that companies provide health benefits to all their employees.

The introduction of Medicare and Medicaid in the 1960's, which is discussed in greater detail in a later section, provided a large amount of government subsidies for medical care. One perceived advantage of these programs was that they provided care for millions of people without taking away physicians' freedom to practice as they saw fit, or patients' ability to choose their doctors freely. However, since a third party was paying the expenses, this system provided a complete dissociation between receiving health care and paying for it (Fogoros, 2).

Another important effect of such governmental subsidization programs was that they helped give rise to new and expensive medical technologies. With the support of the government subsidies, it was possible to pay for costly therapy that was not economically practical under the old direct-payment system. This led for-profit corporations to take an increased financial interest in sponsoring the development of medical advances. Expensive new technologies became available, and were paid for.

Unfortunately, this system could not sustain itself indefinitely. As the cost of health care skyrocketed, employers and governments could no longer afford to pay the rising costs. So the government began trying, with considerable difficulty, to reduce the cost of care. One way in which it sought to do this was by encouraging a competitive marketplace, on the theory that competition keeps prices down. The most significant action taken in this effort was the facilitation of the expanded development of competitive health maintenance organizations (HMOs). This would later prove to be a turning point in the history of health care.

The era of managed care began with the passage of the federal HMO Act of 1973 ("HMO Act"). This act encouraged the creation of HMOs and defined the rules by which these organizations would be governed. The HMO Act also provided interest-free government loans to federally registered HMOs in order to assist their growth. The passage of this act marked the beginning of a trend that would lead to managed care's current dominance of the health insurance industry. ( Section two of this chapter gives a detailed discussion on HMOs and other types of managed care organizations.)

Unfortunately, the founding of the managed care industry did not immediately help to slow the growth of medical expenses. Total health care spending rose from 7.3% of the gross national product in 1970 to 13% in 1990 (Fogoros, 3). By the early 90's, a national crisis was developing. This prompted many, such as then presidential candidate Bill Clinton, to advocate the development of a new system of health care funding and delivery.

President Clinton took office in 1993, and America had a new vision. Soon after his inauguration, the Clinton administration began working on developing what was dubbed the Health Security Act. The Health Security Act promised an increase in the quality and dependability of health care delivery while, at the same time, providing a reduction in costs to consumers. The Clintons' plan sought to guarantee comprehensive coverage for all legal residents of the United States regardless of employment status, age, health, or social status by placing more of the financial burden on the shoulders of the government. In addition, it would have required health plans to conform to national standards of quality that were established by the National Health Board under the provisions of a National Health Act (Fogoros, 3).

This proposal was a massive undertaking for the ambitious new president and his wife. However, the plan was plagued by conflicting interests. Powerful health care corporations launched advertising campaigns in opposition to the Clintons' plan. Additionally, due to disputes between the major political parties, most Republicans in Congress refused to support the act. The expected cost of implementing the plan was a big issue as well, and the question of how to pay for it was a huge stumbling block. People didn't want their taxes raised and politicians didn't want to raise them.

Many feel the biggest reason for the failure of the Clintons' health care reform was the fact that it was never clearly presented to the public in a simple form (Fogoros, 3). It seemed so disorganized that many citizens took on a negative view of the plan, siding with the Republican criticism that this was just

another example of overzealous "big government" tactics. Without the support of Republicans and the majority of the American people, the Health Security Act was finally laid to rest in September of 1994.

After this failed attempt at health care reform, it seemed managed care was destined to dominate the health care market. Unsure of what the future would hold, record numbers of physicians signed with HMOs to ensure that they would not be left behind. Consumers and employers, feeling the burden of ever-increasing insurance premiums, also flocked to HMOs. Nationwide, HMO membership rose from 26 million in 1986 to 60 million in 1995 (Birenbaum, 9). Now more than ever, the health care industry was becoming a business. Consequently, less coverage was being offered, especially for pre-existing chronic conditions (Birenbaum, 9). This trend continued throughout the 1990's, and managed care continued to grow at record rates.

There is no doubt that the health care system is profoundly different today from how it was 80 years ago. A big part of this change is due to the introduction of HMOs and other varieties of managed care. The alleged problems associated with these organizations provide one of the main arguments for physician unionization. Because of this, it is necessary to further understand the system of managed care before the many issues surrounding physician unionization can be addressed.

## 2.2 Types of Managed Care

In order to understand managed care, it is important to examine the topic on multiple levels. It is necessary to examine the inner mechanics of the managed care system as well as the general concerns surrounding this mode of health care financing and delivery. A full understanding of the system begins with understanding the specific types of organizational structures that bear the label of managed care.

The advent of managed health care in the US brought with it an extensive collection of acronyms. Each acronym denotes a particular way of organizing and financing health care delivery. Some of the most important types of these structures are called Health Maintenance Organizations (HMOs), Individual Practice Associations (IPAs), and Preferred Provider Organizations (PPOs). Understanding the intricacies that lie within each type of managed care requires a thorough examination of that system to see who is in charge, who is paying the bills, and what kind of care is being given.

The most well known and most prevalent type of managed care organization is the HMO. An HMO can be described as a conglomeration of physicians under a single administrative rule whose income is received from payers in advance of receiving care (Bloom, 12). HMOs themselves, however, come in many different varieties.

One particular kind of HMO is known as the staff model HMO. A staff model HMO consists of many physicians working under the same roof. These physicians usually range from basic primary care physicians to specialists with extremely narrow areas of expertise. The types of physicians who comprise a staff model HMO are usually directly dependent on the size and financial security of the HMO. That is, a large and prosperous HMO usually finds itself able to justify the services of many different kinds of specialist physicians. Alternatively, a small HMO would be more likely to focus its attentions on fewer areas of non-primary care and purchase specialty services when necessary. The defining characteristic of a staff model HMO is that all activities related to the HMO take place in one organization. (However, if a person's primary care physician decides that an outside specialist would be helpful, the staff model HMO typically has the option of purchasing the services of non-participating physicians.)

There are various problems with staff model HMOs. First of all, the centralization of all services in one common location may be convenient for those patients who live near the center but excessively inconvenient for those who live far from the center. In this form of organization, some patients find it necessary to travel long distances every time they need any kind of medical care. This is especially unfortunate in terms of emergency care. Another problem is the lack of choice of physicians in a staff model. Joining a staff model HMO usually means that a patient has to sacrifice a large choice of physicians for the set of physicians who work under the umbrella of the HMO. These physicians are encouraged, in turn, to use the services that are available under the same HMO. In practice, however, patients in a staff-model HMO can still be referred to an outside practice if such a referral is medically necessary.

An Individual Practice Association is another type of HMO. IPAs are very similar to staff model HMOs in the respect that the physicians involved are under a certain amount of centralized administrative control. However, the physicians who join an IPA HMO model maintain their current workplaces and

patient panels, but they are given additional patients and salary from the HMO (Bloom, 57). There are usually very few restrictions on whether an IPA physician can service patients outside of the HMO.

In terms of physician autonomy, the IPA model still suffers from the same problems as the staff model HMO; physicians practicing under such an organization may feel pressured to use only the services offered by their IPA. In terms of location and patient access, the IPA model is *potentially* less problematic because of the wide variety of locations in which an IPA office can exist. There is an element of luck involved in this case. Depending on the type of care a patient requires, there may or may not be an easily accessible physician within the IPA to provide the required service. Thus, patients may occasionally be referred to a physician who is relatively inaccessible.

A Preferred Provider Organization is different from an HMO in that the payment for services is not made in advance. Payment occurs using the traditional fee-for-service method (Bloom, 71). This sort of arrangement is referred to as a 'preferred provider' situation because lower co-payments are offered to patients who utilize the services of physicians within that PPO organization. That is, the amount which the patient must pay for the service provided is less when a 'preferred provider' is utilized. This type of organization deserves mention by virtue of the fact that it is a fairly new way of trying to solve the problems associated with health care payment and delivery. Unlike a traditional HMO, the PPO allows patients the option of leaving the confines of the PPO, but by doing so they forfeit some of the financial discounts associated with staying inside of the PPO. Many traditional HMOs also have a PPO arrangement, which allow patients to seek care outside of the HMO's organizational structure. This sort of system offers patients more freedom of choice than is offered by the usual HMO.

The Network Model HMO is a logical extension of previously discussed managed care models. This model simply groups various types of managed care organizations together under the umbrella of a single administration. Such an organization could include several IPAs and staff model HMOs, all of which exist under a single administrative rule. Predictably, Network Model HMOs are usually much larger in size than other types of HMO models (Bloom, 83).

Practicing within the confines of an HMO means that certain restrictions are likely to be placed on the shoulders of the practicing physician. Two mechanisms imposed on many HMO physicians are

utilization review and preadmission certification. These methods, which many HMOs employ, are used to limit unnecessary expenses, but there are concerns that they may severely inhibit physician autonomy.

With utilization review, the HMO's administration monitors the program of care for a particular patient and makes judgments concerning the continuation or termination of that care. If a procedure is deemed unnecessary by the administration, it may be denied to the patient. Preadmission certification is a procedure through which the administration can confirm or deny a patient's right to be treated in a particular hospital. Providing care constantly subtracts from the HMO's usable funds. If utilization review and preadmission certification result in restrictions in the amount of care that is delivered, costs incurred by the HMO can potentially be reduced.

However, utilization review and preadmission certification can be in direct opposition with physician autonomy. It is often alleged that these restrictions force physicians to focus on limiting costs incurred by the HMO, rather than on providing optimum care to their patients. The loss of physician autonomy has been said to be at the root of numerous injustices against patients in various HMOs ("Damaged Care", 1).

As mentioned earlier, an HMO provides a prepaid service. Patients pay a capitation fee in advance for care that they may or may not receive. That is, capitation fees are always paid in advance by the patient regardless of how many services they receive throughout their term of care. The patient who eventually falls ill must pay basically the same fees as a more fortunate patient who remains healthy, even though the patient who falls ill requires more services. This means that it is in an HMO's best financial interest to keep its patients healthy.

Generally the HMO model encourages spending on what is called preventative care (Bloom, 19). The adoption of health education on various topics and smoking cessation groups has the potential to limit the amount of actual care that may be necessary in the future. In the eyes of the HMO's administration, it is wiser to take precautions against subscribers falling ill than to blindly hope that subscribers do not fall ill. The costs of educating HMO members are often less than the costs of later providing extensive medical care to its members (Campion, 339).

Under the HMO model, some of the burden of budget discipline is usually placed on the shoulders of the practicing physician. In the eyes of the administration, it is the physician's duty to ensure that he or

she provides the patient with no more care than is necessary. HMOs ensure adherence to such policies by mechanisms such as utilization review and preadmission certification.

There are a large number of organizational philosophies that govern the many different types of managed care organizations in existence. Managed care organizations, however, are not the only answer to the question of how health care should be administered and delivered. With the increasing costs of medical care and perceived problems with managed care organizations, the idea of government-provided national health insurance has been gaining popularity. The next section introduces the concepts of national health care and how it has affected the health care systems of foreign countries.

## 2.3 National Health Care Systems

When the Clinton administration was drafting its new health care plan in the early 90's, those involved opted to avoid enacting what is know as a "single payer plan" – a plan that would finance universal health care via the government. Such a plan would take the burden of health care funding basically off the shoulders of individuals and corporations and make it the responsibility of the government. The Clinton plan avoided this for several reasons, including the fact that it would have meant eliminating many existing insurance companies -- especially managed care companies (Birenbaum, 7). Instead, the Clintons sought to include these organizations in the new system. Another reason the Clinton administration decided against a single payer plan was that it would not have been a sound political move to implement such a costly program at a time when the government was operating with a huge deficit. However, many people still advocate the adoption of such a system, arguing that it could provide physicians the freedom to practice as they wish -- and more importantly -- would guarantee coverage to every citizen.

The idea of a national health insurance plan for the United States is not by any means a new one. Various groups have been advocating the adoption of such a plan since the early 1900's. Although the issue was raised as early as 1912, as part of Theodore Roosevelt's Bull Moose campaign (Holahan, 1), the first president to publicly endorse government health insurance was Harry S. Truman (Poen, 1). Truman spent a great deal of effort during his presidency in trying to get Congress to adopt a national health

insurance plan. However, he was unable to gain the support he needed. Strong opposition from the American Medical Association helped to thwart his efforts. Additionally, the political climate at that time was not favorable for Truman. Many people thought of national health insurance as socialistic, and therefore in opposition to American ideology (Poen, 1). Since Truman's time, however, many western nations have adopted some type of national health care funding. Some of the most notable examples are the United Kingdom, Germany, and Canada.

### 2.3.1 United Kingdom and the National Health Service

The British National Health Service (NHS) was founded in the year 1948 in response to the lack of comprehensive health care service availability in the United Kingdom. The system was designed to provide the necessary funding to care for the entirety of the British population.

The aim of the NHS was to provide comprehensive health care to all those Britons who required it. This ideal of comprehensive care for all has, in recent decades, been crippled by financial and resource constraints. With an annual budget of approximately $37 million, U.K. physicians and administrators claim that the program is under-funded while government authorities claim that the funds are being mismanaged (Basch, 161) .

Whether it is the result of mismanagement or the lack of adequate funding, this financing problem manifests itself in many ways -- such as long waiting lists for elective surgery. Also, some patients are forced to wait up to 18 months to receive hospital tests and elective care. Allegedly, nearly half of the United Kingdom's cancer patients are unable to receive the necessary care under the NHS ("DMV", 1). Long waiting lists can translate into very poor statistical chances for survival. Under the NHS, however, a patient is allowed to procure the services of a private practitioner provided he has the necessary funds.

Most hospitals in the United Kingdom are currently under national control, although private health care is not disallowed. During one of the major reorganizations of the NHS in 1974, 4,400 private hospital beds were placed in nationalized hospitals (Basch, 161). However, patients who choose to take advantage of private health care make up only 2% of the population (Basch, 161). Nevertheless, private health

services are in such demand that most private health providers are currently operating at capacity ("DMV", 1).

Patients are not the only participants in the British health system who are experiencing dissatisfaction. A recent interview of 2/3 of the physicians working under the NHS showed that 80% of that group would consider abandoning the system if it remains in its current state (Elia, 1).

British physicians are reimbursed by the state when they take on the responsibility of caring for patients. The pool of patients a particular physician serves is known as his/her panel. The level of reimbursement provided by the government is directly related to the number of patients that a physician has on his/her panel, regardless of the number of services provided. Therefore, NHS physicians are encouraged to increase the size of their panels rather than provide more medical services to the patients they have. This situation is similar to an HMO capitation arrangement in the United States. It is potentially dangerous, as it may encourage minimal care delivery to a large number of patients.

The British NHS is somewhat analogous to having a single, gigantic HMO dominating the health care financing scene. Some of the problems associated with an HMO arrangement are magnified in the NHS. Because of the provision of seemingly free care, patients are not conscious of the costs. Untamed health resource usage can increase costs and dissatisfaction among all participants in the health care system.

### 2.3.2 Germany and the Sickness Funds

When Otto von Bismarck created his health insurance plan in 1883, the German system of health care financing consisted of privately funded insurance programs known as sickness funds. If a citizen wished to procure the services of a physician, he/she would sign a contract with -- and pay dues to -- this sickness fund. This sickness fund would, in turn, negotiate and assemble a contract with a corresponding physician organization. The contract provided that these physicians would provide care to the members of the sickness fund in exchange for reimbursement.

Through many reorganizations of the German health system, sickness funds have gone from being private organizations to nationally controlled organizations. The overall system is known as statutory

health insurance, or SHI. Members of SHI have half of their premiums paid by their employers and the other half deducted from their wages. The unemployed and the elderly have the costs of their care covered by the employed, a result of a German belief in solidarity (Ulrich, 1). In total, about 13% of the population's wages are deducted for the purposes of paying sickness fund premiums (Ulrich, 1).

Currently, all types of care including long-term hospitalization are covered under the SHI. About 88% of the German population is insured under the SHI with the remaining portion of the population opting to utilize private health insurance (PHI) schemes (Ulrich, 1). As is the case in the United Kingdom, private health insurance is available in Germany.

Whether working under SHI or PHI, physicians are reimbursed based on the number of services that they provide to patients. In the SHI system, a budget cap limits physician payment. Should the number of services provided exceed a predetermined amount, no more money will be paid to the physician organization for the completion of that particular service. The level of financial reimbursement received by the physician being paid through SHI is based on the German Uniform Evaluation Standard, or GUES, a state-controlled mechanism that determines the amount of money that will pass between the hands of sickness funds and physician organizations.

Germany spends 10.5% of its GDP on health care, a figure that is second only to the US which spends 13.5% of its GDP on health care ("Industry Analysis", 1). This spending, however, has afforded a large number of hospital beds and physicians relative to the population. The large number of hospital beds and physicians suggests that the German health care system will be able to bear the burden of its increasingly aged population.

### 2.3.3 Canada and National Health Insurance

While many western industrialized countries have some form of national health insurance, perhaps most relevant to the United States is the single payer plan which has been adopted in Canada. Beginning in 1948, the Canadian government began a gradual phasing-in of government financed health care; this was completed in 1968 with its comprehensive national health care insurance plan (Andreopoulos, 1). Canada now provides government-financed health care to all its citizens. Of all the

countries that have implemented single payer plans, Canada is the most similar to the U.S. in terms of size, standard of living, culture, and government. Because of this, the Canadian plan is of great interest to those who advocate a similar system for the United States.

There are some characteristics that distinguish the Canadian system from other forms of national health care that have been implemented. One important factor is that the regional provincial governments are the ones responsible for actually carrying out the national health insurance plan; this allows the system to be tailored to each region -- deemed essential in such a large country. Also, physicians are reimbursed by a traditional fee-for-service system, rather than on a salary or capitation basis.

Ever since the Canadian plan was implemented, it has served as a model for many of the national health plan advocates in the U.S. The single payer plan has become generally accepted by Canadian citizens and health care providers, and time has shown that most of the early fears about the potential consequences of this restructuring were unwarranted (Andreopoulos, 3). The appeal of guaranteed health insurance for the entire population is the main advantage of a national health care plan.

Although it has been suggested that a single payer plan would be successful in the United States, such a change would inevitably require some people to make sacrifices; notably, managed care companies and other insurance agencies would lose some power if their financial role was turned over to the government. Additionally, national health insurance would place the burden of payment upon the government and the taxpayer. Also, historically, U.S. organized medicine has offered fierce opposition to the universal health care movement since its genesis. This opposition has been based primarily on the fear that a single payer health plan would result in the enslavement of the medical profession by the government (Durante, 1). It is mainly for these reasons that past United States health care reform efforts have shunned this system.

However, there are currently many domestic proponents of a national health care system. These supporters of a national health care system claim that such a system would provide many advantages over the current private insurer system -- including the promise of universal coverage.

For example, U.S. hospitals spend twice as much on billing and administration costs as Canadian hospitals due to the more than 1,500 private insurers in the United States (Himmelstein, 272). Also, the lack of deductibles and co-payments in a national health plan could increase the utilization of preventative

treatments. Preventative treatments result in lower long term costs in that they often prevent expensive and complicated procedures in the future.

## 2.4 History of U.S. Governmentally Subsidized Health Care

Since the very early part of the 20th century, there have been various initiatives to get the government involved in providing health care to America's citizens. In the decades following the Second World War, the government began to take on a much more pronounced role in the health care industry.

The most important action taken in this area was the creation of the Medicare and Medicaid programs in the 1960's. These programs established the government as the largest single payer of health care expenses (Birenbaum, 15). How and why did this happen? In order to answer that question it is first necessary to understand the history behind these programs.

The proliferation of employer-provided health insurance plans during and after World War II led to a sharp rise in the popularity of health insurance. Unfortunately, many people who were not receiving this insurance coverage as an employment benefit could not afford to pay for it themselves. This caused many citizens to go without health insurance, which was beginning to be viewed more and more as a necessity.

Around this time, citizens began to advocate government action to improve the health care system. President Truman took an active role in government health care policy. Although opposition from various groups -- most notably the American Medical Association (AMA) -- eventually counteracted his attempts to establish a universal national health insurance plan, Truman's efforts helped lay the groundwork for the founding of future government health care plans (Poen, 1).

In 1950, federal legislation was enacted to improve access to medical care for the needy (HCFA, 3). In the following decade, more measures would be taken to provide access to the poor and the elderly. The 1960 Kerr-Mills Bill established a program called Medical Assistance to the Aged, which is sometimes viewed as the precursor to Medicare (Moon, 25). However, this and other programs in place at the time

were very small in scale compared to the government programs that would come into being in the mid-1960's.

The 1964 elections, an outstanding victory for the Democratic Party resulted in a newfound focus on the health care issue. The AMA had flatly opposed government health financing programs from the start, fearing that they would take away physicians' authority over medical decisions (Campion, 71). After the 1964 election, however, the introduction of some form of government health coverage seemed inevitable. Hoping to keep these programs small, the AMA shifted its efforts to limiting eligibility, arguing that comprehensive coverage for the poor and aged would be better than partial coverage for everyone (Moon, 28).

The proposal which was eventually introduced by Congressman Wilbur Mills called for the creation of two separate programs: Medicare and Medicaid. Medicare was to cover persons aged 65 and over, providing hospital insurance, as well as optional subsidized Supplementary Medical Insurance for physician services (Moon, 29). Medicaid was the companion to Medicare. Its purpose was to provide medical care to welfare recipients and other low-income individuals who could not afford to pay for health insurance (Moon, 29). These programs were created as amendments to Social Security and were passed in 1965 (HCFA, 4). In 1972, Medicare was expanded to cover disabled persons less than 65 years of age in addition to the elderly (Moon, 31).

Funding for Medicare is provided by federal government payroll taxes and members' premiums. Medicaid is funded jointly by the state and federal governments, and the states are responsible for administering this program within federally established guidelines (Coughlin, et al., 9). Because of these funding systems, Medicare places a much greater financial burden on the federal government; much of the financial burden of Medicaid is carried by the states.

Physician reimbursement under Medicare was initially made very generous, and no restrictions were placed on what care could be given (Moon, 63). This was designed to encourage physicians to participate in the program, amid opposition and threats of boycotts from medical organizations such as the Association of American Physicians and Surgeons (Moon, 30). The lack of restrictions, coupled with efforts to provide comprehensive coverage amid the constant increase in cost of medical technology, has made Medicare a very expensive program.

Starting in the 1980's, it became apparent that hospital costs and physicians' fees were growing too rapidly. As a result, Medicare was a frequent target in budget reductions. Every budget proposal submitted by presidents Reagan and Bush during the 1980's proposed large cuts in Medicare programs (Moon, 3). However, total financial expenditures continued to grow even when programs were cut. In response to these rising costs, new Medicare payment schedules were created for both hospitals and physicians.

In order to combat the rising in-patient hospital costs paid by Medicare, the notion of Diagnosis-Related Groups (DRGs) was introduced as part of the 1983 Prospective Payment System legislation (Moon, 50). DRGs hoped to encourage hospital efficiency by offering hospitals a fixed monetary amount per service in advance of rendering medical services. This advance payment is in contrast to paying after the fact for services that were administered by the hospital.

The amount to be paid to the hospital was based on the status of the patients who were admitted into the hospital. Upon admission, each patient was classified as belonging to a DRG based on the nature of his/her condition. DRGs for more serious conditions afforded the hospital more funds than DRGs for less serious conditions (Moon, 51).

Hospitals usually receive no more and no less than the amount determined through their patients' DRG classifications. If a procedure ends up costing the hospital less than the amount provided by the DRG, the hospital can keep the difference. However, if a procedure costs more than the amount provided by the DRG, the hospital is expected to bear the loss. Advocates of the DRG system payment system argued that working with fixed monetary amounts would encourage hospitals to operate more efficiently.

Some physicians claim that DRGs are potentially detrimental to the health of patients. Hospital administrators wishing to operate at peak financial efficiency may encourage discharges of patients who are not yet healthy enough to be discharged (Himmelstein, 270).

In the 1980's, physician fees were growing even faster than hospital costs (Moon, 15). Physicians were paid -- retrospectively -- relatively large sums through Medicare when performing expensive and complicated procedures. On the other hand, most physicians had little incentive to provide preventative care and maintenance because these services were reimbursed at a relatively low level. In 1986, Congress

established the Physician Payment Review Commission (PPRC) whose purpose was to find an alternate method for the determination of the level of physician fees under Medicare.

In 1987, the PPRC developed the resource-based relative value scale. This system was designed so that physician services could be ranked and assigned a monetary value (Moon, 65). The resource-based relative value scale was first administered in 1992. This system's reimbursement levels implied that procedures such as surgery had a lower relative value than former payment levels indicated and that simple procedures such as office visits had higher relative values (Moon, 66). (High valued procedures earned more income for physician than low valued procedures.) Since the establishment of the resource-based relative value scale, many formerly well-compensated physicians and surgeons now feel that they are being cheated and undervalued (Moon, 76).

During the 1990's, the government's role in health care funding became increasingly significant. Prior to 1990, about 58 to 60 percent of health care costs were paid by private funds (HCFA, 6). By the end of the year 1999, the amount of health care spending that was attributable to the *government* had grown from 40% in 1990 to 51% (Fogoros, 3). This fact is extremely significant in that it means that the government is now paying for the majority of all the nation's health care costs.

## 2.5 American Medical Association

The American Medical Association (AMA) was established in 1847. Ever since its founding, it has been a major political and economic player in the medical industry of the United States. To this day the AMA continues to use its power to influence health legislation and to sway both professional and public opinion.

### 2.5.1 Purpose of the American Medical Association

The official purpose of the AMA is "to promote the science and art of medicine and the betterment of public health" (Campion, 46). The major components of the AMA include its House of

Delegates, its Board of Trustees, and its dues-paying physician members. Each component of the AMA has a unique role in the organization.

The House of Delegates was formed in 1901 as a response to the lack of a reliable and consistent method of electing AMA officials (Campion, 78). The responsibilities of the House of Delegates were assumed gradually. At the present time the House meets once a year to elect AMA officials and to discuss general policy concerns of the AMA.

The AMA's Board of Trustees, a more powerful organization than the House of Delegates, meets 5 to 6 times a year for the purposes of discussing issues more specific in nature than those discussed by the House of Delegates. For example, in the year 2000 the Board of Trustees attempted to develop an official policy concerning electronic mail communication between physicians and patients (AMA, "Report of the Board --").

Lastly is the large number of physicians (about 40.5% of the nation's physicians) who voluntarily associate themselves with the AMA by paying dues and attending meetings (Kent, 1). All of these organizations within the AMA work together to try to shape the direction and behavior of medical care in the United States.

Some of the AMA's activities include physician representation, information gathering, information warehousing, and the maintenance of educational standards. The AMA attempts to influence the government through the issuance of legislative proposals. Also, the AMA informs the public and the press through the publication of its opinions concerning the direction and the state of the medical profession.

Also, this organization offers information to the public in the form of newspapers like the *American Medical News* and journals such as the *AMA Drug Evaluations* (Campion, 46). *The American Medical News* presents itself as an unbiased source of news concerning legal developments related to medicine -- as well as developments in medical economics. *The AMA Drug Evaluations* allow physicians to procure current information on various medications. Information that can be found in The *AMA Drug Evaluations* includes procedures for correct drug usage and comparisons between drugs that are often used for similar purposes.

In a manner resembling the census activities of the United Stated government, the AMA also maintains a vast database of information pertaining to physicians who are currently practicing in the United States. As of 2001, this database holds information on 690,000 practicing physicians (AMA, "AMA-On-Line --"). Types of information that can be found concerning a particular physician include his or her specialties, medical achievements, and, in some cases, office hours.

Finally, the AMA is a participating member of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), an organization that evaluates and accredits health care organizations across the nation (Campion, 48). Other members of the JCAHO include the American Hospital Association and the American College of Surgeons. The United States government relies on the judgment of the JCAHO; for example, those hospitals participating in the Medicare program must be certified by the JCAHO.

Undeniably, the AMA is a very influential organization in the field of medicine. It has been said that "no other voluntary organization commands such power within its area of interest as does the AMA" (Campion, 49). There have even been occasional reports that those physicians who choose not to involve themselves with the AMA are subject to professional ostracism (Campion, 49).

The AMA claims to represent all of its members in a fair manner. Studies have shown that the behavior of the AMA as a whole seems to be dependent on the wishes of the majority of its members and not solely on the decisions of the House of Delegates and the Board of Trustees (Campion, 57).

In the early 20$^{th}$ century, the AMA formed within its ranks the Council on Medical Education. The purpose of this Council is to examine and suggest new standards for medical education in the United States (Campion, 4). Through a series of reports and studies of particular educational institutions throughout the country, the AMA has created new standards for domestic medical education. For example, in 1910 the AMA released a report known as the Flexner report. This report provided revealing information on the state of many institutions of medical education. Through publication of statistics concerning domestic educational institutions and comparisons with foreign institutions of medical education, the Flexner report is often claimed to have helped to greatly reduce the number of ill-equipped institutions throughout the nation (Campion, 4).

### 2.5.2 American Medical Association and Physician Unionization

In late 1999, the House of Delegates of the AMA voted to establish a collective bargaining unit under its control. Traditionally, physicians have held a great deal of autonomy over their profession. As time has progressed, however, more and more physicians have been finding themselves in employee relationships with hospitals and managed care organizations. In these employee relationships, many physicians are beginning to feel that their autonomy and general professional freedom is being threatened.

One aspect of the AMA's solution is Physicians for Responsible Negotiation (PRN). This bargaining unit, the AMA claims, will help to increase the quality of patient care while ensuring the rights of physicians. PRN is somewhat unique in that it has a strict no-strike policy. Ethical directives forbid its members from withholding "essential medical services", although the concept of what is considered "essential" is not clearly defined (Jaklevic, "AMA to Wear Union Label", 2).

Supporters see PRN as an alternative to traditional unions, which many feel are an inappropriate choice for medical professionals. Nevertheless, the precedent set by traditional blue-collar labor unions is quite relevant to the physician unionization movement.

## 2.6 History of Unionization in the United States of America

The status of labor in the United States was at one time very different than it is today. Until the fairly recent past, the American laborer had little or no voice in negotiations with big business.

The labor movement in the United States began in the 19$^{th}$ century with the intent of securing and protecting the rights of the laborer. Prominent organization of the labor movement began with the Knights of Labor and is currently primarily represented by a union conglomeration known as the AFL-CIO. Through many trials and tribulations, the labor movement has been successful in securing and extending the rights of laborers throughout the nation.

Unionization has helped to place more power in the hands of the laborer. The physician unionization movement hopes to empower physicians. While physicians are not commonly seen as laborers, they are the first-hand providers of medical service to patients. While one group may manage care and another may pay for care, physicians are the caregivers. Just as laborers are the hands of

management in other industries, many physicians are also the hands of management in the medical care industry.

The early American labor movement and the physician unionization movement have many similarities. The early American labor movement was very controversial in its time and the physician unionization movement is extremely controversial at the present time. In addition, the early American labor movement sought a balance of power between labor and management whereas the physician unionization movement seeks a power balance between physicians and medical administrators. Because of these parallels, it is relevant to include a brief history of the American labor movement -- in both medical and non-medical settings -- in our discussion of the physician unionization movement.

### 2.6.1 Early American Labor Movement

The labor movement in the United States was not created instantaneously. It was the product of years of hard work and dedication by many individuals. Throughout its relatively short history, the movement has been represented by numerous organizations including -- but not limited to -- the Knights of Labor, the Federation of Organized Trade and Labor Unions, the American Federation of Labor, and the Congress of Industrial Organization.

The first labor union in the United States was created in Philadelphia in 1827, The Mechanics Union of Trade Associations (Taft, 1). This organization was created by local skilled workers frustrated with working conditions. In addition, the organization was concerned with factors affecting the general quality of the average laborer's life such as the lack of proper public schooling, mandatory requirements to serve in the militia, and imprisonment for debt (Taft, 1). Contemporary government regulations allowed employers to, by today's standards, mistreat employees. The members of this early organization felt that the best way to make their voices heard was to unite and contest what they felt were the unfair practices of their employers. In 1828, this union attempted to strike in order to establish a ten-hour work day. The strike failed ("A Curriculum of U.S. Labor --", 1).

Of note also is The National Trades Union, which was formed in New York City in 1834. Although the activities of The National Trades Union made very little historical impact, the organization itself claimed the distinction of being the first non-local labor union in the United States (Taft, 1). This

labor union was created through the efforts of workers from Boston, Brooklyn, Philadelphia, New York, Newark, and Poughkeepsie. However, The National Trades Union did not survive the economic depression of 1837 (Taft, 1).

During the 1850's, industry in the United States was forced to function in a new environment. Products created in different locations were now able to compete with each other. No longer was the consumer forced to purchase goods from a local producer. Commercial competition across local borders was becoming a reality for the first time. This competition created a need for more refined methods of organization. Often, poor local products could no longer dominate in the presence of previously unavailable quality goods manufactured elsewhere. This widespread competition revealed that many unskilled workers had been producing substandard products that ignored accepted standards and procedures.

The National Typographic Union was created in 1852 as the first national union in the United States. This union brought with it many advancements in the printing industry, including homogenous price scales for services and blacklists on which to keep track of notoriously unskilled workers (Taft, 2). The main focus of The National Typographic Union was the acquisition of rights pertaining to job safety and other job rights, such as the right to refuse to work on Sunday (Taft, 3). The union collected dues annually from local constituent unions. These dues were to be used in the support of The National Typographic Union's activities. Activities for which the dues were levied included supporting the interests of affiliated striking local unions. Despite the potential benefits offered, many members of local constituent unions were unwilling to pay dues (Taft, 4).

A meeting of labor organizers in 1851 in Pittsburgh resulted in the creation of the Federation of Organized Trade and Labor Unions. The first chairman of this committee was future influential labor leader Samuel Gompers (Taft, 13). One of the first activities of this Federation was the rallying of support for a limit of eight hours for one full day of work. While the issue was favored within the Federation by a vote of 23 to 2, the Federation itself lacked the influence and voice to truly make such an idea a reality. For this reason and others, the Federation of Organized Trade and Labor Unions is described as having been "anemic and ineffective" (Taft, 21).

The Noble Order of the Knights of Labor was created in Philadelphia in 1869. Uriah Stephens, the first to hold the title of Grand Workman within this organization, described the Knights of Labor as "the parent of principles, the house of reforms, and the educator of the masses" (Taft, 21). The Knights of Labor also claimed that it was a voice for the plight of the oppressed American worker.

Those affiliated with the Federation of Organized Trade and Labor Unions had contempt for some of the activities of the Knights of Labor, including its establishment of competing unions in common locations and the admission of former expelled members of the Federation into their ranks (Taft, 25). Tensions between the Federation of Organized Trade and Labor Unions and the Knights of Labor continued until the Knights of Labor ceased to hold any sort of influence during the 1890's.

The 19th century produced more than just the Knights of Labor and the Federation of Organized Trade and Labor Unions. The American Federation of Labor (AFL) was founded by Samuel Gompers and other like-minded individuals in Columbus, Ohio in 1881. Its stated purpose was to protect skilled laborers in the United States. It came into existence twice during the 19th century: once in the year 1881 and again in the year 1886 (Preis, 1). Financial difficulties destroyed the initial inception of the AFL, forcing it to reform in the year 1886. The AFL eventually became an increasingly influential force in the labor movement under the leadership of Samuel Gompers and successfully supported various local strikes around the nation, such as the national strike for the eight hour work day in 1886.

### 2.6.2 United Mine Workers

The United Mine Workers (UMW) was created in 1890 by the National Progressive Union as an organization intent on defending the rights of coal miners across the United States. This sort of defense was especially useful for mine workers as they suffered many acts of demoralization and wage cuts at the hands of their employers. The AFL and the UMW were closely linked during the late 1800's. In 1897, for example, the AFL donated $500 (one-third of its entire treasury) to help support a UMW strike in the state of Tennessee (Preis, 137).

In 1919, a coal miner named John L. Lewis assumed the presidency of the UMW. During this year and those surrounding it, many coal miner strikes took place in various parts of the United States. One

example that stands out in history is a 1920 coal strike in Kansas. After President Woodrow Wilson declared that the Kansas strike was illegal, the UMW officially cancelled the strike. However, swayed by the words of a miner named Howatt, a portion of the miners (10,000 of them) continued to strike in open defiance of both the President of the United States and the UMW leadership ("Coal Mining Timeline", 1). The United States government presented fierce opposition because it feared that there might be a coal shortage. At the time, coal was a very important source of energy. Soon after the commencement of the strike, replacement workers were brought in to populate the mines and the strike was ended.

After this strike, the Governor of Kansas -- fearing another strike -- established the Kansas Court of Industrial Relations. This newly established Court had power over businesses in Kansas and reserved the right to settle labor disputes in any manner that it saw fit. However, the Court turned out to be rather ineffective; the United States Supreme Court often refuted its rulings. In 1925, the Kansas Court of Industrial Relations was dismantled by the state ("Coal Mining Timeline", 1).

John L. Lewis of the UMW rose through the ranks of the labor movement and eventually became a very well known and influential leader. The true strength of his popularity became apparent during the AFL presidential election of 1921. Lewis presented Gompers with his most serious challenge for the presidency in years, receiving 12, 324 votes to Gompers' 25, 022 votes (Preis, 4). While he did not ever win the presidency of the AFL, John L. Lewis eventually became the founding president of the very influential Congress of Industrial Organization (CIO) in 1935.

### 2.6.3 Congress of Industrial Organization

Lewis first voiced his disappointment with the lack of support for industrial workers (coal, steel, rubber, textiles, etc.) from the AFL in an AFL convention in 1938. The AFL was unwilling to support the nation's industrial workers because it felt that unions were for only skilled workers. A vote raised by Lewis at the convention in 1938 to offer support to industrial workers lost 18,024 votes to 10, 993 votes (Preis, 42). This evidence of open dissension among the ranks of the AFL prompted the creation of the CIO.

The CIO was formed in 1938 out of the ranks of the AFL. This organization was formed by committee members of the AFL in response to the AFL's lack of support for mass production industrial workers. The founding members, John L. Lewis being the most notable, wished to create an organization that would speak for the industrial workers in the same way that the AFL had supported the nation's craft workers in the past. It was apparent that there was a need for some kind of change starting in the early 1930's. For example, in 1931, 2,937,925 manufacturing workers suffered -- on average -- 9.4% wage cuts and 213,028 coal miners suffered wage cuts of 16.2% (Preis, 8). Many members of the AFL refused to concede to supporting industrial workers as many members of the AFL considered industrial workers to be "riff-raff, rubbish, and strikers" (Preis, 41).

During World War II, many years after the formation of the CIO from the AFL, the two organizations found themselves working together on a number of issues -- despite the fact that they still had disagreements. By 1955, the CIO joined with the AFL to form the AFL-CIO. As one organization it continues to speak for the labor movement in the United States.

### 2.6.4 Monopsony Power in Labor Markets

A monopoly is a situation in which the seller of a product is the only seller on the market. A monopoly seller has a great control over the market on a particular item or service. Those who wish to procure this item or service must go through this seller. That is, potential purchasers will eventually have to deal with the monopoly.

A monopsony is much like the inverse of a monopoly. In a monopsony there is one buyer -- whereas in a monopoly there is one seller. In a monopsony, most selling of a particular good or service must be to one buyer, the monopsonist. In order for a market to truly be monopsonistic it must be difficult for other buyers to enter the market.

When a company must hire labor, it chooses potential employees from a pool of people known as the labor market. The people in the labor market wish to sell their time and services to a company. If there is a competitive labor market, then the people in the labor market (the sellers of labor services) can choose to sell their services to any one of the many companies (the buyers of labor services) that wish to purchase

such services. If there is a monopsonistic labor market, the sellers of labor services are forced to offer their services to only one company because only one company in the area has a demand for their services.

A monopsony market comes with consequences. Because a monopsonistic company is the single purchaser of services, it can choose to purchase its labor at a relatively low price. Because it is not compelled by competition, the monopsony will -- in equilibrium -- pay a wage that is well below what the competitive wage would be. In addition, the power of the monopsonist can often allow it to be oppressive to its employees -- who often have little choice other than to sell their services to the monopsony. Unions can be used to control the purchasing power of a monopsony.

### 2.6.5 Union Power in Labor Markets

Unions that are participating in a labor market have the ability to control the supply of workers and, consequently, have some degree of control over the wages that are paid to those workers. A union in a labor market can work somewhat similarly to a monopoly in a goods or services market. It has the power to set a wage rate that is potentially non-competitive just as a monopoly has the power to set a selling price that is potentially non-competitive.

In a goods or services market, profit maximization is the goal of the monopoly. In a labor market, the goals of the union may be more ambiguously defined. For example, the union may wish to achieve maximum union member employment -- or it may wish to procure the maximum possible wage for a small percentage its members.

Unions are able to affect the wage rate primarily by controlling the supply of workers available in the labor market. In a competitive labor market, the wage rate paid by employers to employees is determined by an uncontrolled supply of laborers and the demand for the labor that these laborers are able to provide. By limiting the supply of laborers available in the labor market, a union is often able to obtain a higher than competitive wage rate for its members. The downside to this is that with the higher than competitive wage rate comes a lower number of employed union members. Alternatively, a union can increase the supply of labor in such a way as to achieve -- at a lower wage rate -- a larger level of union member employment.

While it is clear that a union is able to exert control over the supply of laborers in a labor market, it may not be so clear that a union can also affect wage rates and employment levels by manipulating the demand for that labor. Changing the demand for labor can be achieved through increasing worker productivity or, conversely, forcing management to employ more labor than it needs (i.e., "featherbedding"). In addition, unions can influence consumers to buy only those products created by labor unions. When successful, this causes the demand for union labor to rise (Baumol, 691).

At times, the power of the union to control labor supply and wage rates may be limited by the existence of a powerful purchaser of labor -- the monopsonist. In a labor market consisting of a powerful union and a monopsonistic purchaser of labor, union leadership and management may participate in collective bargaining. Such collective bargaining can lead to levels of wages and employment approximating what would occur in a competitive labor market (Feldstein, 446).

### 2.6.6 Union Power Versus Monopsony Power in Labor Markets

Collective bargaining takes place between firms and unions for the purposes of arriving at wage rates in unionized labor markets. In addition, collective bargaining can be used to determine benefits offered to laborers such as pensions, paid holidays, and health insurance (Baumol, 694). In a collective bargaining situation, both sides have tactics that can be used to achieve their respective goals.

In order to secure either a higher wage rate, a stronger benefits package, or both, a union can either threaten a work slow-down or a strike. In a work slow-down the union instructs its members to decrease their productivity in order to decrease the overall efficiency and profitability of the firm. An extension of the idea of a work slow-down is the strike. In a strike, the union instructs laborers to cease working. A firm dependent on union labor can be halted by such a tactic.

While the tools of work slow-down and strike can provide bargaining leverage for the union, the firm is not powerless in collective bargaining sessions. For example, a firm may pose a lock-out, which is management's voluntary shutdown of the firm. Locking the workers out is similar in practice to a strike but the lock-out is enacted by the firm in order to secure its demands. During a lock-out wage payments by the company cease and employee incomes suffer accordingly. The firm decides when lock-out ends, just as the union decides when the strike ends in the case of a union strike.

Unions and monopsony buyers of labor are able to exert control over one another by way of these tactics. The mutual threat of lock-outs and strikes ensures the neither side is totally dominant in the situation -- both parties have something to lose. Therefore in a monopsony buyer situation with a powerful union, the power of the each party is tamed by the power of the other. Neither union nor firm is allowed to exert total control over the labor market.

### 2.6.7 Nurses' Labor Markets

Nurses' labor markets are often either monopsonistic or oligopsonistic. Because many nurses are secondary wage earners (i.e., they are not the primary wage earners in a household), they often have little geographic mobility (Feldstein, 443). Having little mobility forces them to sell their services to the local monopsony. They have the option of either selling their services to that particular set of hospitals, nursing homes, etc., or not selling their services at all.

Under the Taft-Hartley Amendment of the National Labor Relations Act, employees who are not in supervisory roles are permitted to unionize (United States, "Labor Management Relations Act"). Therefore, nurses without supervisory roles are allowed both to form collective bargaining units and to strike.

As has been shown above, collective bargaining with a medical care monopsony can offer many benefits to nurses. Higher wages, greater employment opportunities, as well as fairer employee treatment practices can often be attained via collective bargaining.

It is becoming increasingly important for hospital employees to remain aware of the market situations in which they are involved. A careful monitoring of anti-trust laws as applied to hospitals is of major concern to hospital employees as the number of hospital mergers across the nation is growing steadily (Feldstein, 447). Hospital mergers result in fewer hospitals. Fewer hospitals translate into fewer buyers of labor services. When there are few buyers of a labor service, the labor marker tends to become monopsonistic. The decrease in the overall number of employers as a result of these mergers means that the potential for hospital monopsony/oligopsony is growing.

### 2.6.8 Power of a Professional Union in Medicine: a Contemporary Example

Although the numbers of unionized nurses have been relatively low in the past, there have been cases where nurses and other medical laborers have exercised their right to bargain collectively.

Collective bargaining and striking in the medical care industry became a reality in Worcester, MA in 2000. A situation at St. Vincent Hospital in that city proved that bargaining with a hospital can be an effective tactic. The nurses working at St. Vincent Hospital conducted a strike and successfully had their demands met. Even though nurses are not physicians, this strike offers some insight as to what could happen if physicians were to strike.

Tenet Healthcare is one of the nation's largest health care companies. The company bought St. Vincent Hospital in 1997 and then proceeded to build the new Worcester Medical Center, which included a new St. Vincent Hospital.

After building the center, Tenet began to demand mandatory overtime of the employed nurses in the form of double shifts. Starting on March 31, 2000, St. Vincent nurses began to strike in protest claiming that mandatory overtime could be potentially dangerous to patients who might suffer from poorly delivered care from fatigued nurses (Eckelbecker, 1).

After the strike of the nurses commenced, the Tenet Corporation brought in about 200 replacement nurses from a nurse staffing agency in Colorado (Price, 1). During the strike, the Massachusetts Department of Public Health was alerted to at least two cases of negligent behavior by these replacement nurses. In one case, a nurse offered the wrong newborn to a mother for nursing and in another case a post-operative patient was left unattended. Following these events there was a full-scale evaluation of the new staff and its behaviors.

Many other parties --in addition to the striking nurses -- were interested in bringing the strike to an end. For example, The Fallon Community Health Plan, a health maintenance organization and former owner of the St. Vincent Hospital, began to divert a "significant portion" of its day surgery business into the competing Worcester Surgical Center as a result of the strike (Pope, 1). Also in support of the cause of the nurses was the Massachusetts Teachers Association (MTA). On May 5$^{th}$, 2000 over 1,500 members of the MTA rallied to support the striking nurses. Also, Democratic Senator Edward Kennedy described the demands of the Tenet Corporation as "intolerable" and publicly urged them to cease their overtime

demands so that the strike could end (Eckelbecker, 1). After 42 days of striking, the demands of the St. Vincent's nurses were met.

The success of the nurses' strike suggests that other strikes in the medical care industry (e.g., among physicians) could possibly be successful. Although the role of physician is different from the role of a nurse, both professions play a very important role in maintaining the health of patients.

## 2.7 Labor Legislation in the United States of America

The development of labor law in the US has had a significant impact on the growth of the American labor movement. Acts that have both facilitated and limited union power in the US include the Norris-Laguardia Act, the National Labor Relations Act, and the Taft-Hartley Act.

Before 1932, union behavior was actually considered a criminal activity. Union organization and collective bargaining could be halted by the government at the request of management (Carrell, 14). With the passage of the Norris-Laguardia Act in 1932, the rights of unionized employees were greatly extended.

The Norris-Laguardia Act stated that government authorities could not restrict the formation of unions or halt union strikes through court order (Carrell, 14). The Act also prohibited management from coercing employees to abandon union membership as a prerequisite for employment.

The National Labor Relations Act (NLRA) was passed by Congress in 1935. Senator Robert Wagner, who proposed the NLRA, claimed that it would secure commerce through the protection of employees and level the inequality of decision-making power between employers and employees. The NLRA provided for many new rights for laborers and imposed restrictions on behaviors of employers.

Under the NLRA, employees were granted the right to organize unions and join pre-existing unions. These unions were given the right to bargain with employers and the power to use strikes or the threat of strikes as a bargaining tactic.

The NLRA also defined many activities that were illegal for employers. Since 1935, it has been illegal for employers to refuse to bargain in good faith with employees or their representatives. Employers were also forbidden from discriminating against employees who were seeking to exercise their new-found rights under the NLRA (Carrell, 17).

The NLRA also provided for the establishment of the National Labor Relations Board (NLRB) (Preis, 10). The NLRB is responsible for enforcing the rules for management that are delineated in the NLRA.

It was alleged by many that the NLRA was strongly biased in favor of labor unions. In 1947, an amendment was made to the National Labor Relations Act known as the Taft-Hartley Act. The Taft-Hartley Act placed more restrictions on the behaviors of unions and employees than did the NLRA. Under the Taft-Hartley Act, supervisors were made exempt from the protections of the NLRA. Also, unions were denied the right to bar employment to those potential employees who were not interested in union membership. In addition, the Taft-Hartley Act required that unions participate in bargaining at the request of employers. This is similar to the NLRA requirement that employers participate in bargaining at the request of unions.

According to the revised NLRA, most physicians are afforded no bargaining rights under the NLRA and the Taft-Hartley amendment. They are denied these rights for one of two reasons: they are either independent contractors and not employees at all, or they are employees with supervisory duties (Pahn, 120). As noted above, employees with supervisory duties were made exempt from NLRA protections and rights under the Taft-Hartley Act.

Before the passage of labor laws, the powers of labor and management in the US remained undefined. The aforementioned acts were vital in defining the limits of both labor and management. As the status of professionals changes, it may be necessary to update or augment laws relating to the unionization rights of such professionals. Just as labor law was responsible for defining the American labor movement, legislation will be necessary in forming and guiding the physician unionization movement.

## 2.8 Conclusions

The current state of medical care in the United States is the result of many years of political, moral, and economic forces. The 20$^{th}$ century brought a plethora of medical advances, but many of these

advances came with an enormous price tag. Finding ways to pay for medical care has been a major concern ever since.

Alternative methods of health care administration and delivery have evolved. Managed care organizations were developed in order to improve efficiency and to combat rising costs in the medical industry. With the failure of former President Clinton's health care reforms in 1993, managed care corporations secured an even stronger foothold in the medical industry. The profit-driven model of many managed care organizations is the target of much criticism from physicians and patients alike.

Medical organizations such as the American Medical Association have voiced support for the empowerment of physicians and patients to combat the strength of managed care organizations. Many people support legislative changes that would allow employed physicians with supervisory duties to bargain collectively with health care organizations without the fear of legal retaliation.

Legislation such as the Taft-Hartley Act, which was created before the public's current concerns with the medical care industry, may have to be amended to adapt to the changing face of the medical care industry. The past must not be forgotten, however. The development of organized physician groups is somewhat reminiscent of the struggle of the early American laborer and the growth of labor unions such as the AFL-CIO.

Unionization in the medical industry -- at the professional level -- has already occurred. For example, the nurses at St. Vincent Hospital in Worcester recently conducted a successful strike against the ownership of that hospital. Events such as this have helped to change the public view of unionization as it applies to medical workers.

The American medical care industry has had a rich past. The future, however, remains uncertain. The information in this chapter has provided a basis for the study of the current trend toward physician unionization. In order to further understand this movement, an examination of present activities in the U.S. legislature is required, as well as an analysis of recent events in the U.S. and abroad that may have an impact on the future of unionization in the American health care system.

# Chapter III: Procedure

The information base upon which this report was written was acquired primarily through electronic and physical library research. This research was conducted in two main phases. The goal of the first phase was to obtain a working knowledge of the American healthcare system, the history of healthcare and medical insurance in the United States, and the American labor movement of the 20th century. The acquisition of this foundational knowledge was crucial in determining the direction and goals of the project. The goal of the second phase was to study the physician unionization movement and current events affecting this movement and its future. Because this project took place during a pivotal period in the physician unionization movement, maintaining a knowledge of current events was essential in proceeding with the project.

The purpose of the first phase was to gain an understanding of how the question of physician unionization came about. This required knowledge of both the healthcare industry and the organized labor movement. The primary resources for the first phase were published books obtained from Worcester Polytechnic Institute's George C. Gordon Library, and the University of Massachusetts Medical Center's Lamar Soutter Library. Information gathered in this phase was used to build a solid foundation of knowledge on which to base the remainder of the project.

The second phase of research dealt mostly with current events in the physician unionization movement. Most of the information attained in this portion of the project came from periodical and journal articles. The journal collection at the Lamar Soutter Library was the primary source of data, although some of the information came from magazines, Internet sites, and other assorted sources. Because of the authors'

initial unfamiliarity with the workings of the medical industry, a careful focus was placed on viewing the opinions of experts on both sides of the issue. It was found that these opinions were available in abundance.

Once a considerable body of information was assembled, it was possible to examine in more detail the issue of physician unionization, the lessons that could be learned from the past, and the possible implications for the future. Additional research into highly specific aspects of the topic was performed as necessary. A thorough analysis of all the information obtained during the research phase of the project was conducted so that a sensible, beneficial course of action could be recommended.

# Chapter IV: Results and Analysis

The physician unionization movement is beginning to secure a foothold in the medical care industry. This controversial movement is now becoming one of the top issues of debate in the medical community. It is becoming increasingly apparent that the physician unionization movement has the potential to significantly affect the future of health care in this country. This chapter contains information concerning recent physician unionization activity, a discussion of the opinions of supporters and opponents of unionization, and an analysis of possible outcomes for the future.

The United States government has been participating in the development and application of labor laws for well over a century. Chapter II discussed some of the important labor legislation of the past. More recently, some legislators have attempted to establish and secure certain physician rights to unionize through bills such as the Quality of Health-Care Coalition Act of 1999 (HR 1304). If physicians are allowed to unionize, it may help to keep managed care corporations under some degree of physician control.

In addition, there are other legislative measures being taken to prevent alleged abuses by managed care organizations. Congress recently passed a series of patient-empowerment bills known as the "Patients Bill of Rights". The intent of these bills is to allow patients to secure some legal power to offset the excess power of managed-care corporations. Should they become law, these bills may help to solve some of the same problems targeted by physician unions. The potential implications of all of these bills are explored in this chapter.

Organizations such as Physicians for Responsible Negotiation (PRN), the Union of American Physicians and Dentists (UAPD), the National Doctors' Alliance (NDA), and the Federation of Physicians

and Dentists (FPD) are initiating change with great dedication. In the recent months, there have been many new developments that will help shape the future of physician unionization. In this chapter, the recent activities of these organizations are reviewed.

The attitudes of the influential American Medical Association (AMA) will certainly help to shape the physician unionization movement -- now and in the future. As noted in Chapter II, in 1999 the AMA formed its own bargaining unit, Physicians for Responsible Negotiation. The creation of PRN has helped to establish the role of the AMA in the unionization movement. This chapter investigates the methods through which the AMA is likely to exercise its power with respect to the physician unionization movement.

The physician labor movement has also drawn support from the American Federation of Labor-Congress of Industrial Organization (AFL-CIO). The AFL-CIO has expressed concern with the growing number of physicians who are becoming salaried employees. In an official statement, the AFL-CIO said that it encourages physicians to "join with other professionals as active participants and partners in the American labor movement" (Burda, 3).

It should be noted that the physician unionization movement is not entirely without internal conflict. It is actually a composite of several groups, each with its own agenda. Although they may be similar in many ways, some of the major physician organizations have differing views on a few key issues. These differences, combined with opposition from the enemies of the entire movement, are likely to make the growth of the movement a slow and labored one. The various obstacles facing the movement, both internally and externally, are discussed in this chapter.

The future of the physician unionization movement remains uncertain. Nevertheless, an analysis of events which have already taken place leads to some predictions concerning both the direction this movement will take and the effect it will have on the health care industry. In order to make such predictions, it is first necessary to carefully examine the events that are currently unfolding.

## 4.1 Recent Physician Unionization Developments

In the past decade there has been a great surge in union-related activity in the health care industry. The government, health care companies, unions, and physicians are in the process of exploring options, and trying to find answers to the many questions that have been raised regarding this issue. Legislators are working to adapt labor and antitrust laws to deal with the changing medical care industry in the most constructive way possible.

As Congress and state governments try to come to an agreement regarding physician unionization, the various bargaining units already representing physicians continue to make their collective voices heard. The AMA's Physicians for Responsible Negotiation (PRN) is beginning to establish itself as a viable option for physician groups looking to negotiate with corporate medicine. Meanwhile, established physician unions like the Union of American Physicians and Dentists (UAPD), the Federation of Physicians and Dentists (FPD), and the National Doctors' Alliance (NDA) are already representing thousands of medical doctors around the country. The purpose of this section is to provide coverage on the most recent activities in both the federal and state legislatures and in the existing physicians' unions.

### 4.1.1 New Legislative Proposals

Recent attempts to weaken antitrust regulations against physicians have been met with considerable resistance. Legislation on the state and federal levels has been halted or otherwise disabled. Specific examples of difficulty can be seen in the death of the Quality of Health Care Coalition Act, the 1999 actions of the D.C. Control Board in Washington, cumbersome regulation in Texas, and in the failure to pass effective physician unionization legislation in Pennsylvania. However, with the recent House and Senate passage of the Patients' Bill of Rights, there is some hope for legislative progress to be made toward protecting patients from the alleged abuses of managed care organizations.

#### 4.1.1.1 Patients' Bill of Rights

In the past, patients who were the victims of negligence at the hands of managed care organizations found that they had little power to retaliate. In order to seek reparations, a patient was often forced to file suit against his/her practicing physician. In certain cases, however, these suits would have been more suitably targeted at the managed care organizations whose practices may have encouraged such negligence. United States legislators have recently considered this possibility.

Recently, Congress has been working to pass a collection of regulations known as the Patients' Bill of Rights. This legislation seeks to empower patients who feel that they have been unfairly treated by managed care organizations. This bill does not offer new rights to patients who are uninsured but rather gives extended rights to the already insured. In reality, there have been multiple versions of the Patients' Bill of Rights.

Two sets of legislators endorsed their own versions of the bill. One bill, known as SB889, was sponsored by senators Bill Frist (R- TN), John Breaux (D-LA), and Jim Jeffords (I –VT). The other bill, known as SB872, was sponsored by John McCain (R- AZ), Edward Kennedy (D-Mass) and John Edwards (D-NC) (Babington, 1). The Breaux-Jeffords-Frist Bill was defeated by a vote of 59 to 36 in the Senate in 2001 (Babington, 1).

Attentions now have been focused solely on the McCain-Kennedy-Edward bill. This bill was passed in the House and a modified version was passed in the Senate in August of 2001. The versions of the McCain-Kennedy-Edwards bill passed in the House and Senate differ primarily on the specifics of how and where a patient is allowed to file a law suit against a managed care organization.

The McCain-Kennedy-Edwards bill would guarantee access to specialty care. That is, under this bill patients would not be required to consult a primary care physician in order to procure the services of a specialist. In addition, patients would be able to present opposition to the direction of the medical care that has been provided and managed care organizations would not be allowed to offer financial incentives to physicians who limit the application of medical care. The bill would also prohibit so-called 'gag clauses' in physician contracts (Dewar, A01). A 'gag-clause' prevents a physician from discussing treatment options with patients.

The version of the McCain-Kennedy-Edwards bill that was passed in the Senate places more liberal constraints on the abilities of patients to sue than does the version passed in the House. The Senate version of the bill provides for the ability to sue in state courts, file class action lawsuits, and seek greater financial rewards in all lawsuit related conditions (Dewar, A01). The version passed in the House limits financial rewards to the monetary value of the care that was allegedly denied the patient and confines suits to federal courts (Dewar, A01). In addition, the House bill does not provide for class action suits.

Currently, patients who wish to file suit against managed care organizations can only do so in federal court for amounts equaling the amount of care that they feel they were denied. Both versions of the bill would allow for more lawsuit possibilities against managed care organizations. Support for the bill has been found among such organization as the AFL-CIO and the American Medical Association

Both versions of the bill have been criticized by both employers and insurers, however. Those in opposition to the bill claim that the passage of the bill would result in frivolous lawsuits that would further increase the nation's medical costs (Goldstein, A05). This increase in medical costs, the bill's detractors say, would increase the quantity of the nation's uninsured.

If Patients' Bill of Rights legislation is eventually signed into law, it will help patients to take action against their managed care organizations if they feel those organizations are being unfair or abusive. This may help to improve the treatment of patients under managed health care plans. Furthermore, the elimination of gag-clauses would remove one major constraint that managed care organizations often place on their physicians. However, before such legislation can be enacted, both houses must pass the same version of the bill. Additionally, the bill that is passed will almost certainly need the support of President Bush, who is currently in opposition to the Senate version of the bill (Goldstein, A05). Since the passage of the Senate bill in August, there have been no new developments with regard to this bill.

If the Patients' Bill of Rights is enacted, it would help to limit the powers currently held by managed care organizations. They would be forced to be more responsive to the needs of both patients and physicians in order to avoid legal retaliation. This empowerment of patients and physicians could curb the need for the growth of the physician unionization movement. The possibilities of legislation such as the Patients' Bill of Rights suggests that unionization is not the only answer to the overabundance of managed care power.

### 4.1.1.2 Quality Health-Care Coalition Act

In 1999, Rep. Thomas Campbell (R-CA) introduced a bill into the United States House of Representatives aimed at improving the situation of physicians under managed care plans. The so-called "Campbell Bill", more formally referred to as the Quality Health-Care Coalition Act, would act as an anti-trust waiver for physicians, allowing them to bargain collectively and negotiate with health plans without having a fear of legal retaliation. The bill drafted by Rep. Campbell and his colleagues stated that physicians engaged in collective bargaining with managed care companies would be "entitled to the same treatment under antitrust laws as the treatment to which bargaining units which are recognized under the National Labor Relations Act are entitled in connection with such collective bargaining" (HR 1304). This bill would, therefore, allow all physicians to be recognized as employees when negotiating with managed care companies. However, the bill contained a provision prohibiting physicians from striking , saying that the antitrust exemption provided by the bill "shall not confer any right to participate in any collective cessation of service to patients not otherwise permitted by law" (HR 1304).

The Quality Health-Care Coalition Act passed through the House of Representatives with a 40-vote victory in 1999. It did not, however, survive in the Senate, largely due to strong opposition from Senate Majority leader Trent Lott and the Federal Trade Commission (FTC).

FTC chairman Robert Pitofsky was quoted as saying: "The bill, while appealing in its apparent simplicity, threatens to cause serious harm to consumers, to employers, and to federal, state and local governments" ("Facts About H.R. 1304", 1). The FTC feared the Act would encourage price-fixing among physicians.

Supporters of the bill contended, however, that the purpose of the Quality Health-Care Coalition Act was to allow the physician to provide the best possible care for patients by limiting the role of managed care organizations in the medical decision-making process (Lewers, 1).

The fate of the bill became unclear when Campbell, the primary supporter of the bill, lost his position in the House of Representatives. Fellow representative and co-sponsor of the bill John Conyers (D – MI) was originally planning to reintroduce the bill sometime in 2001. However, the bill has still not been

re-introduced. Since the inception of the United States government's war on terrorism in September of 2001, legislative focus has not been on physician unionization legislation (Snider, E5). Supporters of the bill had hoped that it would be introduced under the Bush administration, because George W. Bush showed concern for physician negotiation rights when he was governor of Texas.

### 4.1.1.3 Texas State Legislation

In 1999, Governor George W. Bush signed a Texas state law allowing joint physician negotiations with health plans in Texas. Texas Senate Bill 1468 was passed by the Texas legislature and signed by Governor Bush in that year. This bill allowed self-employed physicians to negotiate with health plans. It utilized a concept known as "state action doctrine". The term "state action doctrine" comes from a 1943 Supreme Court decision which allows for exemption from federal antitrust regulations, provided that the state oversees the negotiations (AMA, "Collective Bargaining/Antitrust Relief", 1).

Unfortunately, not one group of physicians was able to effectively take advantage of the new law. The Texas Medical Association said that the lack of utilization of the law was due to the cumbersome regulations governing applications for joint physician negotiation with a health plan (Greene, 1). Under these regulations, it would take approximately one month for the necessary paperwork to be properly processed. In addition, the law required physicians to travel different avenues depending on whether their concerns were fee related or patient-care related (Gaudagnino, "Fate of Joint --", 1).

The Texas Medical Association drafted a strategy designed to help provide economic and strategic guidance to Texas physicians who were interested in filing for joint negotiation under the new law (Gaudagnino ,"Fate of Joint --", 1). In addition, the organization made suggestions to the Texas attorney general concerning the rules for negotiation application.

In 1999, a group of orthopedic surgeons in San Antonio Texas, in response to the enactment of Texas Senate Bill 1486, applied for joint negotiations over fee and non-fee related concerns with a number of health plans. These physicians were supported by the FPD.

According to FPD President Jack Seddon, the first application for negotiation under the new law was returned by the state attorney general within thirty days of the submission with suggestions for

resubmission (Gaudagnino ,"Fate of Joint --", 1). The FPD claimed that the process of filing for joint negotiation was excessively cumbersome, requiring the submission of irrelevant physician data (Gaudagnino ,"Fate of Joint --", 1).

### 4.1.1.4 Washington D.C. Legislation

Also in 1999, the legislative branch of the Washington, D.C.'s government -- known as the Council of the District of Columbia -- passed the Physicians' Negotiation Act by a vote of 10 to 2. The bill was also signed by the mayor of Washington, D.C. However, it was subsequently halted by the District of Columbia Control Board. The District of Columbia Control Board, created in 1995 by William Clinton, is responsible for monitoring budget deficits and cash shortages in the District of Columbia.

The Physicians' Negotiation Act was intended to provide some antitrust immunity to physicians practicing in Washington D.C. It would have allowed physicians to conduct negotiations with health plans under the supervision of Washington D.C. government officials. The Physicians' Negotiation Act explicitly prohibited the possibility of strikes or boycotts (Weiss, 1).

The District of Columbia Control Board claimed that the waiver would have resulted in spending that was in excess of the operating budget for the District for that year. Such revocation of the bill, even when it had support from both the Mayor and the Council of the District of Columbia, is testament to the controversial nature of physician unionization.

### 4.1.1.5 Pennsylvania Legislation

Multiple physician anti-trust waiver legislation bills have been introduced in Pennsylvania over the past few years. Not one of these bills has yet become law. Regardless, a discussion of a sampling of these bills follows.

In 1999, state Senator Dick Tilghman (R) introduced and sponsored S.B. 1052 at the urging of the Pennsylvania Medical Society. The bill allowed for physician negotiations with health plans concerning the topic of quality of patient care. The bill also allowed for fee-related negotiations -- but only when the

health plan involved in the negotiations was known to have substantial market power, as determined by its market share or the discretion of the state attorney general (ACP-ACIM, 1). In order to insure that all potential negotiations would be conducted in good faith by the health plan, the bill included the requirement that all negotiations must be overseen by the state attorney general (this right is similar to the right to have negotiations conducted in good faith that is offered to regular employees under the NLRA). The language of the bill did not specifically prohibit strikes. However, the absence of this prohibition is currently inconsequential as physician strikes are currently disallowed by federal law.

Senator Tilghman said in 2000 that it is unlikely that the bill will be passed for many years. He says that opposition from health care providers is too strong and that the general public as well as legislators are not yet sufficiently educated on the topic (Guadagnino, "M.D. Joint --", 1).

Also in 1999, Representative John Yudichak (D) introduced the Physician Collective Negotiation Act, also known as H.B. 1816. This bill allowed for physician negotiations to take place only concerning quality of patient care; it specifically disallowed fee-related negotiations under any circumstances. In addition, this bill explicitly prohibited physician strikes. Representative Yudichak weakened the wording of the bill to increase the chances that it would become law (Guadagnino, "M.D. Joint --", 1). The bill has not become law and there are no plans for reintroduction of the bill. Senator Tilghman -- sponsor of SB 1052 -- suggests that HB 1816 may be a helpful source of wording when drafting later a version of SB 1052 (Guadagnino, "M.D. Joint --", 1).

The Pennsylvania Medical Society has recently focused its efforts on the rectification of problems with medical malpractice in the state. This focus on malpractice reform has left little energy to be devoted to physician unionization, making the immediate future of physician unionization in Pennsylvania unclear.

### 4.1.2 Physicians for Responsible Negotiation

Physicians for Responsible Negotiation (PRN) was officially launched on November 24, 1999, after being approved by an AMA vote earlier that year ("Physicians for Responsible Negotiation Launched", 1). Recall that PRN was briefly introduced in Chapter II.

In its short existence, PRN has been active in the battle for physician and patient rights. Situations which are examined in this section include those at the Wellness Plan in Detroit, Lutheran General Hospital in Illinois, and Concentra Health Services in New Jersey.

The Wellness Plan is a Detroit-based HMO with over nine hundred physicians ("Detroit Doctors Elect --", 1). In March of 2000, the Wellness Plan's staff physicians became the first group to officially organize under PRN. Organization among the physicians had been approved by the NLRB two months earlier, despite opposition from the Wellness Plan. The HMO appealed the NLRB decision, claiming that many of the physicians had supervisory power and therefore had no right to bargain, but the court again ruled in favor of the physicians. PRN has put a great deal of emphasis on getting physician groups approved by the National Labor Relations Board. Once a bargaining group is recognized by the NLRB, employers -- including HMOs --are required to discuss the group's concerns in good faith (Adelman, 298).

In recent years, resident physicians filed against the Lutheran General Hospital in Park Ridge, Illinois. The nature of the complaints have ranged from the cost of its employee health insurance program to the lack of a formal procedure through which resident physicians can register complaints. In August of 2000 -- in an attempt to prevent angry resident physicians from unionizing -- the hospital threatened to close "some or all of its residency programs" as well as reduce residents' salaries (Romano, 1). Dr. Robert Bernat of PRN claimed that "Lutheran General broke the law" when it threatened to close its residency programs (Romano, 1). On November 9, 2000, the NLRB agreed -- at the urging of PRN -- to recognize residents at the hospital as a collective bargaining unit ("PRN Wins Bargaining Rights", 1). In March of 2001, Lutheran General Hospital agreed not to close any of its residency programs or to threaten resident physicians who have sympathies for PRN (AMA, "Lutheran General", 1).

New Jersey physicians employed by Concentra Managed Care, Inc., have also looked to PRN for support. Concentra controls a nationwide network of occupational health care centers. Some physicians working for the plan have claimed that working conditions are unsuitable for the purposes of providing patient care ("NJ Physician Group --" , 1). The involvement of PRN seemed necessary as many problem resolution requests to management had been ignored. In August of 2000, PRN filed a petition with the NLRB on behalf of Concentra's New Jersey physicians ("NJ Physician Group --", 1). As of July 2001, Concentra was still contesting the bargaining rights of their physicians (Agovino, 1).

### 4.1.3 Union of American Physicians and Dentists

The UAPD is the only medical labor organization from the 1970's to have survived until this day (Pahn, 1). The UAPD is a member of the American Federation of State, County and Municipal Employees (AFSCME). Currently, the UAPD boasts upwards of 5,000 members ("Patients Before Profits", 1).

In 1998, Robert Sinaiko, a California physician, was alleged to have used unorthodox techniques in treating his allergy patients. Because he utilized techniques that had not gained widespread acceptance, the Medical Board of California (MBC) charged Sinaiko with unprofessional conduct and incompetence. Such charges could have resulted in the revocation of the physician's medical license.

The MBC is responsible for the issuance of medical licenses and the investigation of alleged illegal activities in California medicine. While the MBC is composed primarily of physicians, it does have a disciplinary council composed primarily of lawyers ("The Doctor --", 1).

Controversy arose because the decision as to whether or not misconduct had taken place was placed in the hands of non-physician administrators. The UAPD became involved when it requested that the MBC not honor the verdict of its non-physician disciplinary council. The main goal of the UAPD in this case was to ensure that the non-physician disciplinarian council of the MBC not be allowed to decide which physician practices are acceptable and which are unacceptable ("The Doctor --", 1).

In 2000, the UAPD drafted a piece of legislation that it claims has been responsible for the cessation of certain unscrupulous practices by certain California based HMOs (UAPD, "New Plan --"). Charles Goodman, M.D. , prompted the draft of the legislation when he became aware of what he considered to be unethical behavior in the HMO that provided him with medical care. He fell ill and when he attempted to contact his physician he was told that his primary care physician was no longer employed by the HMO. Goodman had been guaranteed that he would be able to procure the services of a physician at any time. For this reason, Goodman continued to pay his premiums. In reality, his physician was no longer employed by the HMO. The HMO failed to notify Goodman that his primary care physician was not available.

After Goodman's discovery, legislation was written by Senator Liz Figueroa that prevents similar behavior from taking place in California. The legislation dictates that an enrolled patient must be given thirty days notice by the health plan if his/her primary care physician is leaving the health plan. Also, the patient must be given a set of instructions detailing the method for selecting a new primary care physician should his/her physician leave the plan. Figueroa's legislation was passed and the UAPD claims that it will help the problem in the state of California. The UAPD, however, would like to have this activity prohibited in other states as well.

### 4.1.4 National Doctors' Alliance

The National Doctors' Alliance (NDA) was formed in March of 1999 and actually consists of three separate organizations: the Doctors' Council, the Committee of Interns and Residents, and the United Salaried Physicians and Dentists (Thompson, 1). Currently, the National Doctors' Alliance represents about 18,000 physicians (Thompson, 1). Upon forming, the National Doctors' Alliance became part of the Service Employees International Union (SEIU), an affiliate of the AFL-CIO.

President Barry Liebowitz of the NDA feels that physician unionization is a necessary next step because corporate administrators are beginning to dictate physician working conditions and methods of diagnosis and treatment (Liebowitz, 1). However, he also stresses that collaboration with management is essential because the NDA understands that very little can be accomplished in an adversarial environment. Management and physicians must work together in order to move forward.

Dr. Liebowitz has openly stated that he is not opposed to the prospect of striking. However, his position is that if a strike is going to occur, it should not be because of economic concerns but rather because of quality of care issues (Greenhouse, 1). As a justification for his viewpoint, Dr. Liebowitz said, "sometimes it is better to strike than to allow patients to go into a substandard facility" (Greenhouse, 1).

The NDA has been working to represent the needs of salaried physicians with non-supervisory roles at the Manhattan House of Detention, Rikers Island, and the Metropolitan Hospital Center, which are all located in New York City.

St. Barnabas Hospital began operating the infirmary of Rikers Island in 1998. On February 3, 2000, the Doctors' Council was officially recognized by St. Barnabas as the "sole and exclusive collective bargaining representative" of physicians at Rikers Island and the Manhattan House of Detention ("Rikers Island Doctors --", 1). By June 26, 2000, the Doctors' Council had successfully formed its first contract with St. Barnabas. The contract guaranteed both financial and career security provisions for the physicians represented by the Doctors' Council. [It should be noted, however, that less than a month after this official recognition, St. Barnabas decided to end its contract with the Manhattan House of Detention and Rikers Island, effective February 2001 ("Rikers Island Doctors --", 1).]

On April 18, 2000, physicians at the Metropolitan Hospital Center in New York City -- a teaching hospital of the New York Medical College --voted to be represented by the Doctors' Council for the purposes of collective bargaining ("Metropolitan Doctors --", 1). A bargaining agreement was sought by physicians in order to help remedy poor working conditions and a perceived inability to adequately provide patient care.

Many of the resident physicians who work at the Metropolitan Hospital Center come from the New York Medical College. The New York Medical College expressed opposition to this representation, claiming that many of the physicians to be represented held supervisory positions. The NLRB decided that the physicians at the Metropolitan Hospital Center did indeed have the right to bargain collectively. Despite this vote of the NLRB, the New York Medical College displayed a continued unwillingness to bargain with the Doctors' Council. The New York Medical College said it would not participate in any bargaining because it alleged that many of physicians working at the Metropolitan Hospital Center had supervisory roles (Albert, 1). In November of 2001, the NLRB ruled that the New York Medical College is obligated to negotiate in good faith with the resident physicians of the Metropolitan Hospital Center (Albert, 1).

### 4.1.5 Federation of Physicians and Dentists

The Federation of Physicians and Dentists (FPD) is a union representing both employed and private practice physicians. In addition to providing representation, the FPD seeks to develop, manage, and

present pieces of legislation that would benefit its members. It is the intent of the FPD to improve the working conditions and financial well being of its members through these methods.

The FPD has successfully engaged in lawsuits and representations in Philadelphia, New Mexico, and Florida (Barg, 1). One of the most effective activities of the FPD, however, was the boycott in 2000 of the Merck and Company, a pharmaceutical corporation.

Merck and Company, one of the world's largest pharmaceutical manufacturers, was reported to have joined the ranks of a coalition that intended to halt the progress of anti-trust waiver legislation for physicians (e.g., Quality of Health Care Coalition Act). In fact, Merck's name was mistakenly included in an advertisement by the Antitrust Coalition for Consumer Choice in Health Care -- a group claiming to support competition in the medical care industry by way of antitrust legislation (FPD, "Vote--We Won"). In response to Merck's perceived opposition to the antitrust waiver, the FPD requested that member physicians purchase pharmaceuticals only from Merck's competitors.

Opponents of the decision to Merck products boycott claimed that participating physicians had allowed political concerns to come before patient concerns. The FPD, however, contended that no compromises had been made because there exist many reasonable substitutes for Merck pharmaceuticals. Some of these substitutes include products from Pfizer and Novartis.

A substantial drop in sales figures for Merck resulted as a consequence of the boycott (Pear, 1). Soon after the realization that the boycott was affecting business, Merck made it clear that it had no official position on the topic of anti-trust waiver legislation (FPD, "Vote--We Won").

The FPD was also responsible for a lawsuit against the JFK Memorial Hospital in Philadelphia. This hospital is owned and operated by a fellow member of the AFSCME, District Council 33. The hospital's non-salaried physicians were aroused when it became increasingly apparent to them that the hospital was not providing adequate equipment or an effective nursing staff. In addition, physicians were finding that despite the fact that premiums to the hospital were constantly rising, physician pay was remaining stagnant and the hospital also was experiencing little to no growth ("City Union Tries To Bust Doctors' Union", 1).

When attempts were made to initiate bargaining with the hospital, the hospital continually refused. The hospital also fired many physicians who expressed in an interest in being represented by the FPD. In

2001, the NLRB decided that District Council 13 was wrong to refuse to negotiate in good faith with the physicians of JFK Memorial Hospital (Sklaroff, 1). As of 2001, the NLRB demanded that the hospital be forced not only to negotiate in good faith with physicians but also to offer monetary compensation to fired physicians (Sklaroff, 1).

It is apparent that the activities of organized physicians are exerting influence. This new philosophy concerning the role of the physician has already provoked some in the medical care industry. The effect, both actual and potential, of organized physician behavior cannot be ignored.

## 4.2 Support for Physician Unionization

Although there has been significant debate as to whether medical professionals should organize collective bargaining units -- or "unions", the movement toward such organization has been receiving support from both the labor and medical fields. The AFL-CIO has spoken in favor of physician unions. In addition, the AMA - - as noted previously - - has approved its own version of physician bargaining unit, Physicians for Responsible Negotiation. It is important to examine the roles that these existing organizations have played in the formation of the movement.

### 4.2.1 Traditional Labor Unions

According to John J. Sweeney, President of the AFL-CIO, "Nearly 50 percent of practicing physicians in the United States are now in salaried positions, making them eligible to join unions . . . they need unions because the upheaval in the health-care industry is affecting other health-care workers" (Greenhouse, 1).

All of the labor unions discussed in this section, with the exception of PRN, are either directly or indirectly affiliated with the AFL-CIO. As stated previously, PRN is not affiliated with the AFL-CIO but rather is affiliated with the AMA.

The National Doctors' Alliance, mentioned previously in this chapter, is a product of the AFL-CIO. In March of 1999, the AFL-CIO's Service Employees International Union combined the United

Salaried Physicians and Dentists, The Doctors' Council, and the Committee of Interns and Residents to form the National Doctors' Alliance. The new organization was afforded a one-million dollar annual organizational budget after being created by the AFL-CIO (Farmer, 1).

Also mentioned previously were the legal clashes between the FPD and Pennsylvania's District Council 33 -- a member of the AFSCME and owner and operator of the JFK Memorial Hospital in Philadelphia. Both the FPD and District Council 33 are affiliated with the American Federal, State, County and Municipal Employees (AFSCME) which is, in turn, affiliated with the AFL-CIO. While the AFL-CIO may officially support the FPD, the JFK Memorial Hospital Case suggests enmity between organizations can exist regardless of their mutual affiliations with the AFL-CIO.

There are advantages to having a physician union affiliated with the AFL-CIO -- such as increased lobbying power. The AFL-CIO has firmly established its place in the workings of legislation through its exercise of lobbying power. Also, as can be seen with the monetary support given to the NDA and SEIU, affiliation with the AFL-CIO provides financial benefits.

Being affiliated with the AFL-CIO, however, brings with it all of the enemies and political controversies associated with the AFL-CIO (Kengor, 1). In addition, affiliations with the AFL-CIO can imply Democratic politics. Physicians who harbor alternate political ideologies may feel that cooperating with the AFL-CIO compromises their political belief structures.

### 4.2.2 American Medical Association

The American Medical Association has always been an influential voice in the American medical universe. Consequently, the views of this organization are of great interest whenever there is a new issue facing physicians in this country.

When the members of the AMA voted to sponsor a physician negotiation unit in 1999, this showed that they were open to the concept of organized bargaining for physicians. However, the AMA believed that it and other medical societies were more qualified than traditional labor unions to assist physicians in their organizing efforts (AMA, "Collective Bargaining/Antitrust Relief", 1). It was this belief that prompted the AMA to create its own bargaining unit, Physicians for Responsible Negotiation.

The AMA sees PRN as an alternative to traditional unions, offering what the organization considers a more responsible and professional approach to collective negotiation. After the PRN was formed, spokesmen from both the SEIU and the FPD stated that they would consider an alliance with the new organization. However, the chairman of the AMA Board of Trustees, Dr. Randolph Smoak, said that the AMA was not interested. PRN refused to form these alliances because of its official stance against the possibility of striking (Jaklevic, "AMA to Wear --", 12). PRN organizers had no wish to affiliate themselves with organizations who supported strikes.

Supporters of PRN are careful to distinguish it from traditional unions, arguing that it will help to bring about change without the risk of physician strikes. In a written statement released in September of 1999, then-president of the AMA Thomas Reardon said: "The principles behind PRN -- commitment to the highest quality care, patients' rights, no strikes or actions that would compromise patient care -- are in stark contrast to traditional trade union actions." (Jaklevic, "AMA Union --" 4).

The AMA is currently seeking passage of amendments to the National Labor Relations Act that will give physicians complete freedom in collectively bargaining against managed care organizations (AMA, "Collective Bargaining/Antitrust Relief", 1). Currently, most physicians are prohibited from bargaining collectively as their supervisory duties deny them such rights under the Taft-Hartley Amendment to the NLRA. The desired amendments to the National Labor Relations Act would allow these so-called self-employed physicians to engage in collective bargaining with health plans.

The AMA has also worked to encourage legislative action at the state level. In 1999, the AMA's Division of Private Sector Advocacy successfully collaborated with the Texas Medical Association on its efforts to get the Physician Negotiation Bill (SB 1468) passed in Texas (Levine, 16). Organized physician negotiations under SB 1468 can take place under the supervision of the state attorney general. This is an example of a state's right to utilize a "state action doctrine" which allows anti-competitive behavior to take place in the state as long as such behavior is under the supervision of the state government. The AMA is working to get other states to adopt similar "state action doctrine" policies with regard to physician organization (AMA, "Collective Bargaining/Antitrust Relief" 1).

## 4.3 Obstacles Facing Physician Unionization

Many physicians feel that unionization will be an important tool in preserving both physician and patient rights. There are some groups, however, who feel that unionization could be harmful to the entire medical industry.

While there are countless outright enemies of physician unionization -- as discussed below, there are also those within the physician unionization movement who are divided amongst themselves. The main internal conflict plaguing the movement is the debate over whether physician unions should have the power to strike. Some physicians are against physician striking, while others argue that it is a necessary negotiation tool that should not be taken away. The second part of this section addresses this issue and other issues that need to be resolved in order for the movement to be successful in the future.

### 4.3.1 Opponents of Physician Unionization

Many critics argue that unionization and professionalism are not at all compatible. While the proponents of physician unionization see it as a necessary solution to the abundant powers of the managed care administrators, its detractors see it as a potentially destructive force in the medical care industry.

Current interpretations of antitrust policies are the main obstacle preventing physicians from unionizing on a widespread basis. This is due to the fact that a large percentage of physicians are said to be "self-employed", and a union of such physicians would legally be considered a trust (a group that threatens to reduce competition), rather than a union. Thus, the success of physician unionization depends largely on the passage of antitrust waiver legislation like the Quality Health-Care Coalition Act. However, many people have voiced strong opinions against such legislation, arguing that it would open the door for abuse by physicians seeking to increase their incomes.

Some powerful opponents of antitrust waivers include the Federal Trade Commission (FTC), the Congressional Budget Office (CBO), and the Antitrust Coalition for Consumer Choice in Health Care (ACCC-HC). These groups have all strongly opposed legislation which would remove barriers preventing "self-employed" physicians from unionizing.

The major concern of most opponents is the fear that the passage of a bill like the Quality of Health Care Coalition Act would open the door for anti-competitive practices by physicians -- the type of actions antitrust laws were originally intended to discourage. The president of the FTC, Robert Pitofsky, claims that the passage of antitrust waiver legislation would result in "unscrupulous" practices -- such as price fixing and boycotts -- by physicians (Pear, 1). The Quality Health-Care Coalition Act would have allowed physicians to legally use such tactics without the approval of government regulatory agencies. The U.S. Department of Justice and the American Bar Association have also expressed concern about the potential for abuse of such sweeping exemptions.

Additionally, the Congressional Budget Office claims that unions of "self-employed" physicians would demand higher payments for their services, increasing the costs incurred by private health care insurers (AMA, "Collective Bargaining/Antitrust Relief", 1). This in turn would generate a rise in insurance premiums and could result in a reduction in coverage offered by employers. The end result, the CBO argues, could be a significant increase in the number of uninsured Americans.

The Antitrust Coalition for Consumer Choice in Health Care (ACCC-HC) is a group composed of various physician, government, and insurance organizations that advocate increased competition and strong antitrust enforcement in the medical industry. The ACCC-HC echoes the concerns of the FTC and the Congressional Budget Office concerning physician unionization. In January of 2001, the ACCC-HC sent an open letter to Congress urging it not to pass any legislation similar to the Quality of Health Care Coalition Act. In the letter, the group stated that such a law "would permit physicians to engage in collusive and cartel-like conduct without fear of prosecution under the antitrust laws" (ACCC-HC, 1).

Not surprisingly, many health plans are also opposed to the unionization movement. If physicians' unions increase in strength and membership, health plans will have to relinquish some of their power to the organized physicians. Therefore, health plans could stand to lose some degree of control over their businesses. Many insurers and managed care corporations are members of organizations like the ACCC-HC.

### 4.3.2 Differing Opinions Among Physician Unionization Proponents

Many supporters of physician unionization have contradictory feelings concerning the direction that the movement should take. It is necessary to discuss the various different opinions that exist, especially on topics such as striking and union affiliation.

The most significant issue of debate within the physician unionization movement is the topic of striking. The largest and most active physician collective bargaining organizations have expressed differing opinions on this topic.

Proponents of physicians' power to strike argue that a great deal of a negotiating body's leverage comes from the threat to a strike. If a health plan knows that a bargaining group has sworn not to strike, it is less likely to feel that the physician unit is a threat. As UAPD president Robert Weinmann put it: "If you've given away your best weapon, you're like a general who says in advance he won't use ground troops." (Goodman, 297). He feels that maintaining the threat of a strike is necessary in order to properly negotiate with insurers and maintain physician control over medical decisions.

On the other hand, PRN president Susan Adelman defends her organization's no-strike policy, arguing that withholding necessary patient care is never appropriate under any circumstances. She believes strikes are ineffective, saying that PRN will rather focus on getting NLRB recognition for physician groups, and educating the public (Adelman, 298). Adelman cites the passage of the Patient Bill of Rights in the House as evidence that progress is being made in the move to reduce the power of managed care organizations (Adelman, 298).

The dangers of physician strikes have been seen in foreign health care systems. In recent decades there have been strikes in various countries, including Canada and in France (Loeb, 1) ("French Doctors -- ", A8). The passage of the Canada Health Act in 1984 imposed fines on physicians who demanded to be paid amounts in excess of those provided by the national health insurance. Some physicians, feeling that this imposition transformed them into federal employees, conducted a strike in 1986 and refused to provide care (Loeb, 1). Public response to the strike was extremely negative. These striking physicians were thought to have placed financial concerns ahead of patient concerns.

More recently, in France, a group of private hospital gynecologists and obstetricians conducted a strike on the basis of a lack of hospital resources. As a result, their patients were forced to seek care in public hospitals, which thus received an increased burden ("French Doctors --", A8).

It is evident that a physician strike can result in potential patient harm -- as was the case in Canada -- or in patient inconvenience -- as was the case in France. While the ability of physicians to strike may help to improve organized physician negotiation power, it is potentially harmful to patients and can create enmity between physicians and patients.

Another subject of debate is who is more qualified to organize physicians -- medical organizations like the AMA, or union organizations like the UAPD. On one hand, medical associations have more knowledge of the medical field and are likely to receive more sympathy from the public. On the other hand, traditional unions are more skilled at negotiation, and may be more effective at bargaining with managed care organizations.

The AMA has expressed a strong belief in medical associations as the preferred option for physicians looking for support in negotiations with health plans (AMA, "PRN Readies --", 1). In a sense, PRN is the AMA's answer to the question of physician organization. Physicians who wish to organize, the AMA believes, should do so under an organization, such as PRN, whose affiliation is with the medical community rather than the labor movement.

The UAPD, meanwhile, feels that traditional labor unions are a more effective tool. ". . . a real union, like the UAPD, has a long and successful track record when it comes to negotiating effectively with private payers, hospitals, cities, counties, the State of California, and the Federal bureaucracy", says President Weinmann (Weinmann, 1). Other advantages of traditional labor unions that have been cited include increased access to legislators and skills in public relations (Goodman, 297).

All physician collective bargaining groups, whether or not they are considered unions in the traditional sense, have similar ends. They all state many of the same goals, such as increasing decision making power for physicians, protecting patients' rights, and educating the public. However, the specifics of how these goals can best be achieved are a subject of debate between different groups within this movement. Thus, it is not truly a single uniform movement, but rather a grouping of individual movements.

This lack of a unified movement with common ideas about how to reach its goals is perhaps the greatest obstacle to the spread of physician unionization tactics in this country. However, this dissension is not likely to stop the trend, but merely decelerate its growth as the American health care system continues to evolve.

## 4.4 Analysis

The success or failure of the physician unionization movement will potentially have far reaching effects into the entire health care industry. Physicians, health care insurers, patients, and medical organizations like the AMA would all be forced to adjust to any changes that may be created by physician unionization. The various possible results of this movement must be examined in order to determine what actions can be taken to bring about an optimal resolution.

The first possible outcome is that physician unions would proliferate as did blue-collar labor unions in the early 20$^{th}$ century, having a significant impact on the future of health care. Just as labor unions changed the rules for employers in the industrial world, physicians' unions have the potential to shift the balance of power in the health care industry. Currently, about 5.5% of physicians are in unions (Sherer, 10), compared to 24% of blue-collar workers (Baumol, 686). If physician unionization begins to flourish as the traditional unions have, many groups will be affected by this movement.

Health plans fear a strong physicians' unionization movement. If physicians gain bargaining and negotiating power, health care insurers will be forced to listen more closely to physician concerns. While this may be beneficial for the physician bargaining unit involved, it means that health plans may be forced to suffer a loss of both administrative and financial power. Financial power would be compromised if physicians required greater amounts of financial reimbursement -- or improved equipment and working conditions, which could raise the cost of the care financed by the health plan. Administrative and financial power would be compromised if physicians requested to have more say in the direction that a patient's care would take.

In order to compensate for these financial losses, health plans may be forced to raise their premiums. An increase in premiums would obviously place greater strain on patients and employers who

are forced to pay those premiums. If patients are made to believe that the increase in premiums is the fault of the negotiating physicians, this could damage the physician-patient relationship. In addition, employers -- in response to the increased premiums -- might no longer be able to offer comprehensive health benefits to their employees, or might require employees to pay a higher part of their premiums. As a result, more Americans may end up without health insurance.

There is a danger that unionization could severely damage the physician-patient relationship, especially if strikes were to occur. Unionizing, and especially striking, might give patients the impression that their physicians are more interested in their own financial gains than they are in caring for their patients. This could cause patients to lose faith in their physicians. Trust is arguably the most important aspect of the physician-patient relationship.

However, past events suggest that some medical care workers can strike and maintain support from the public. The strike of the St. Vincent Hospital nurses in Worcester, MA, revealed strong public support for the nurses. While this sort of activity has been tolerated with nurses, the case of the physicians' strike in Canada showed an overwhelmingly negative public reaction. These events suggest that the public may be less accepting of a strike if they feel it is over financial issues rather than quality care issues. Also, since the services provided by physicians are often considered to be more essential than those provided by nurses, public outcry is likely if these services are denied.

Provisions that forbid union members from striking, such as those adopted by PRN, eliminate this threat. However, there are doubts as to whether a union can be truly effective in negotiation if it doesn't have the power to strike. PRN has been successful in getting some groups organized. It is yet to be seen whether these bargaining units will be as effective as hoped. To a great extent, the outcome of these events will help determine the future direction of the movement. If PRN is able to prove its usefulness, it will show that the threat of striking is not essential to effective bargaining, and thereby eliminate one of its main sources of criticism. If, however, PRN-sponsored physician groups are not successful, then more physicians are likely to gravitate toward traditional unions.

The widespread success of physician unionization groups is dependent on government legislation. The first step toward fortifying the movement would be the passage of national antitrust waiver legislation for physicians. A recent AMA report found that 62% of American physicians are either "self-employed" or

"independent contractors" (UAPD, 1). Physicians under this classification are not hospital or health plan employees. Obviously, if these physicians are not permitted to bargain collectively, it will severely limit the potential of the physician unionization movement.

Government organizations such as the FTC and the Congressional Budget Office have expressed displeasure over the prospect of antitrust waivers. This government opposition may prove to be a significant barrier to the proliferation of physician unions. If some groups of physicians are prohibited by law from organizing, there is little that can be done until the applicable laws are changed.

Strong government and corporate opposition suggests that such legislation will not be passed in the near future. Nevertheless, groups such as the UAPD and PRN have managed to win many small victories for physicians. Even if physician unionization never materializes as a unified national movement, its potential in individual cases has already been demonstrated several times. It is in this way that physicians' unions are most likely to be successful. A great physician unionization movement comparable to the industrial labor movement of the early 20$^{th}$ century is not likely to develop in the near future. There are as many differences between the two movements as there are parallels. Physicians are battling for a different set of rights than were sought by early American laborers. However, existing unions will continue to make changes on a small scale.

# Chapter V: Conclusions and Recommendations

The purpose of this project was to provide a comprehensive overview of the physician unionization movement. It has been the intention of the authors to provide insight into the factors affecting the potential for the growth and general acceptance of physician unionization in the United States. Using information gathered from previous publications, a general overview of the medical industry and the current state of physician unionization has been presented. This chapter gives a brief review and summary of the findings, and offers recommendations for legislators, physicians, and the public. Finally, it offers a conclusion and an assessment of the project, its goals, and its limitations.

## 5.1 Summary

The health care industry is at an historical crossroads. The state of both health care delivery, finance and administration is changing rapidly. Physicians are being forced to take on new roles as increasingly powerful managed care corporations are beginning to dominate the industry.

During the past few years, the health care industry has gone through many changes. While technological achievements are advancing the science of medicine on a daily basis, other kinds of change are also taking place. One of the most dramatic and noticeable changes in the industry can be seen in the manner through which physicians are reimbursed for their services.

The shift toward managed care -- as opposed to traditional indemnity insurance plans -- has created a new set of goals and struggles for physicians in the medical industry. Health plans are becoming

more and more powerful as merger after merger creates larger and larger health care corporations. These powerful new corporations wield tremendous decision-making power. Many physicians are finding that it is difficult to maintain an appropriate degree of professional autonomy when dealing with such powerful corporations. This perceived loss of autonomy is also accompanied in many cases by a decreased level of financial reimbursement.

The decreasing number of health plans and managed care organizations is creating monopsonistic labor markets. This increase in monopsony power in the medical care labor markets is making it increasingly more difficult for hospital and health plan employees to wield decision-making power within their organizations. There is a general trend toward increased corporate power and decreased provider power.

In order to preserve financial stability and professional autonomy, many physicians are turning to unions. While not totally unprecedented in the medical care industry, unionization among physicians is a very controversial idea. Like the American labor movement before it, the physician unionization movement has many proponents and many enemies.

Through unionization, groups of physicians are able to exert more influence than that of an individual physician. A union may be able to effectively dispute the decisions of a health plan whereas an individual physician may go unheard. However, the prospect of unionized physicians comes with many concerns about its potential dangers, such as denial of medical service due to physician strikes. These fears make the question of physician unionization a controversial one, with no simple answers.

Past labor legislation is an obstacle to addressing the needs of today's physicians. It is becoming increasingly necessary to develop legislation that will reflect current circumstances in the struggles between physicians and managed care organizations.

Legislation has been proposed at both state and federal levels that will undoubtedly sway the future of the physician unionization movement. Much of the legislation in question is capable of either strengthening or severely weakening the movement. Bills like the Quality Health Care Coalition Act that amend antitrust laws to remove barriers to physician unionization have failed to pass largely due to concerns over the potential abuse of the privileges they would grant physicians.

Physician unionization is experiencing a slow and painful growth. As was the case with the American labor movement of the late 19th century, physicians' unions are encountering a large degree of hardship and opposition. This opposition has been seen to come from varied sources, including the United States government.

Under current legislation, it is difficult for physicians to join together with other physicians and participate in collective bargaining with a health plan. If a physician holds a supervisory role or is self-employed, such participation is illegal. This prohibition is based on legislative regulations and finds its roots in the National Labor Relations Act. In fact, much of today's proposed health care legislation is based around the idea of offering anti-trust waivers to physicians so they can legally negotiate with health plans.

Federal legislative proposals such as the Quality of Health Care Coalition Act, or the "Campbell Bill", have attempted to relax federal regulations against physicians in particular. There has also been local legislation in Texas and Washington D.C. that attempts to achieve similar ends within the bounds of federal law. Such legislation, however, has been met with significant opposition from forces within both government and the medical care industry. Government organizations such as the FTC and the Congressional Budget Office have voiced opposition to such bills mainly for fear of price collusion, boycotts and strikes on the part of organized physicians.

Even within the medical care industry, many physicians and physicians' groups are divided against each other. Some argue that unionization is unprofessional and inappropriate for physicians. Others feel unionization is necessary, yet have differing opinions as to how particular actions should be carried out; the issue of the strike as a union tool is particularly controversial.

The majority of this project has been focused on the acquisition of information regarding the medical industry and physician unionization. With this knowledge in hand, the authors have seen fit to propose some recommendations to physicians, medical organizations, and patients concerning the physician unionization movement.

## 5.2 Recommendations

Different steps must be taken by each group involved in the medical industry. Physicians, physicians' unions, managed care corporations, legislators and patients each must take different steps, not only to protect their personal and institutional well-beings but also to promote cooperation and progress among divided parties.

The policy of the government on the subject of physician unionization is very important. Under current federal policy, self-employed physicians or those with supervisory roles are not allowed to negotiate collectively with insurance companies. Nevertheless, because of the tremendous decision-making power held by managed care corporations, many of the self-employed physicians paid by them function more like employees than independent professionals. For this reason, it is recommended that the federal government provide some sort of antitrust relief for these physicians, so that they may organize bargaining groups to negotiate with health plans.

However, some past legislative proposals have perhaps gone too far. The Quality Health Care Coalition Act, while intended to provide physicians the power to negotiate in order to provide better care for patients, had several features that would have allowed physicians to use unscrupulous tactics such as price fixing. Hopefully, physicians can be trusted to act in the best interest of patients. However, as the FTC pointed out, the Quality Health Care Coalition Act, if passed, would have essentially legalized many potentially unethical actions. It is important that any future antitrust relief legislation place safe limitations on the power of organized physician groups. For example, a walkout or strike by physicians that results in denial of necessary medical services would obviously be very harmful to patients and should therefore remain prohibited.

There are other ways for the government to contribute to solving problems in the health care system. The federal legislature can probably improve the situation through legislation similar to the Patients' Bill of Rights, which is directly aimed at improving health care for patients. In terms of improving the quality of health care delivery, physicians' unions may help, but they may be damaging as well. A real solution is more likely to be found through patient empowerment and education.

Physicians who are currently eligible to join unions have a decision to make. If such physicians feel that they are being prevented from providing quality care, then they must make some effort to resolve

the problem. As demonstrated by industrial labor groups, unionizing can be an effective way to voice common concerns and gain the attention of large corporations. If a physician is eligible to join a bargaining group, and believes that it will help make his/her voice heard, then he/she should do so, in the interest of his/her patients. Medical doctors have a very important job, and they should always do what they feel is necessary to continue doing the best job possible.

Medical organizations like the American Medical Association also play an important role. Such organizations can do a great deal to help physicians organize. While unions may work well in individual situations, one key to continuous improvement regarding issues of patient care and physician autonomy is to continue educating the public through informational campaigns and private sector advocacy programs. The more aware the public is of the problems within the medical industry, the more attention will be given to these problems. A sympathetic and politically active public will yield a sympathetic legislature.

Additionally, patients can take steps to keep themselves informed. Patients should be aware of their physicians' employment conditions. If one's health care is paid for by means of managed care organization, then one should be aware of the practices and policies of that organization. If a patient believes that he or she is not being treated fairly, it is that patient's responsibility to do something about it.

## 5.3 Conclusion

The body of this project comes mostly as the result of library research. There was no experimentation or original data acquisition performed. All information presented in this report has either been published previously or is simply the result of educated predictions by the authors. Its main limitation is the authors' lack of expertise on the topic of health care prior to the commencement of this project.

This examination of the state of health care in the United States and the concept of physician unionization has hopefully helped to provide useful insight into the complexities of this trend. It is hoped that the information and recommendations in this report will prove helpful to physicians, legislators, and patients who are trying to understand the situation and choose the best course of action for themselves with regard to the changing health care industry.

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