

Hospital Unionization Harms the Sick

By David Bier and Iain Murray

Summary: *Nursing is a valued career in a civilized society. It combines helping people with the economic demand for health care. Now, however, this noble profession is the target of an organized campaign by Big Labor to make it yet another source for compulsory dues, at the expense of those whom the health care system is supposed to serve—patients.*

In 2009, Deborah Burger, co-president of the then-newly formed National Nurses United (NNU), proclaimed, “We are going to make sure we organize every single direct care [registered nurse] in this country.” Burger’s organization has done much to advance that goal. Favorable political conditions and rising health care costs have created opportunities for unions to grow in influence in the health care industry. And in 2009, several health care unions put aside their differences and embarked on an unprecedented push for further unionization of hospital, medical care, and nursing home employees. Meanwhile, strikes by previously organized workers have increased in frequency over each of the last three years, which also saw the two largest nurses’ strikes ever.

Desperate for new members, nursing unions are exploring new tactics. These include organizing in states with right to work laws and incorporating religious messages in an effort to organize Catholic hospital employees. This push for members has affected both the number of strikes and the proportion of nurses who are unionized. It has also had negative effects on patient care and health care costs. Strikes put many thousands of patients’ lives and health at risk, and union-



In years past, the Service Employees International Union and the California Nurses Association engaged in bitter fights like this one. Now they’re collaborating.

ization contributes to increased health care prices, which reduces the availability of health care.

Unions on the Move

While private sector unionization has declined in the United States as a whole for decades, the health care sector has been an exception in recent years. Union employment fell from 24 percent of private sector workers in 1973 to under 7 percent in 2011. In absolute terms, total unionization has been sliced in half, from 15 million workers in the 1970s to about 7 million today. Hospital unions have defied this trend by maintaining a workforce presence that is double the national private sector average (14.3 percent). Membership has increased by almost a third

over the last decade, from 687,000 in 2000 to 907,000 today.

In the last three years, hospital strikes have risen dramatically. According to the Federal Mediation and Conciliation Service, 2010

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saw new health care strikes increase by almost 70 percent over 2009 levels, and last year that number rose by an additional 73 percent. In terms of days, strikes increased by 27 percent, rising from under 800 days in 2009 to over 1,000 in 2011. The number of health care workers involved in the 2010 strikes soared by over 800 percent compared to 2009.

These sharp increases in strikes occurred even though the mere threat of a strike can harm the provision of health care. In California, for example, over 100 strikes were threatened in 2011. A single union—the National Nurses Union—carried out 18 of those strike threats, affecting 46 hospitals, which incurred significant costs to prepare for strikes that never came.

To date, the union assault on health care providers has been heavily localized; 84 percent of strikes from January 2009 to January 2012 occurred in just four states: California, New Jersey, Minnesota, and Connecticut. Of those strikes, almost 60 percent were in California, where 23,000 nurses unionized by the California Nurses Association marched off the job in September 2011, in the largest nursing strike in U.S. history. The previous record, set just the year before, was held by 12,000 nurses in Minnesota.

Strikes now occur more frequently and last longer. Also in 2010, 1,500 Philadelphia nurses struck at Temple University's

hospital for nearly a month. Last year, 600 nurses struck after proposed cuts in benefits at Washington Hospital Center in the nation's capital. In December, 6,000 California nurses again abandoned their post, this time right before Christmas.

The unions claim their members receive insufficient compensation for their crucial work, but the details of their current contracts tell a different story. The average nurse at Northern California's Sutter Health Hospitals, for example, made over \$130,000 last year with a pension plan worth \$84,000 per year. Non-salary benefits are also generous at Sutter Health. Nurses receive up to 40 paid days off, and most have an option of a 100 percent employer-paid health benefits plan. Temple University nurses made almost \$40/hour when they struck in 2010—the equivalent of over \$83,000 per year, plus paid vacations and health benefits.

Hospital Union History

In 1935 Congress passed the National Labor Relations Act (NLRA), which made collective bargaining compulsory for most private organizations. Though hospitals were not explicitly excepted, some courts assumed that charities like hospitals were not intended to be included. But a federal appeals court in *NLRB v. Central Dispensary Hospital* (1944) affirmed that charitable hospitals were covered by the Act. In consequence, when the Taft-Hartley Act amended the NLRA in 1947, Congress explicitly excluded "any corporation or association operating a hospital, if no part of the net earnings inures to the benefit of any private shareholder or individual."

For the next two and a half decades, non-profits were generally excluded from the NLRA's collective bargaining requirements, although the National Labor Relations Board (NLRB) made several rulings that allowed unionization at various universities during this time, e.g., Duke University (1971). After large hospital strikes took place under state law in New York City and San Francisco in the 1970s, Congress decided to revisit the issue in order to create a federal system for resolving disruptive health care labor disputes. The

updated law required 10 days notice before a strike in all health care institutions, but did little to resolve the problem of health care strikes. Sen. Peter Dominick (R-Colo.) noted at the time:

"I am concerned that in certain fields in which an impasse between management and employees is reached a resultant slowdown or strike could adversely affect the public interest. The health-care field is one such area.... States such as mine [have] 25 counties with a total of 600,000 residents with only 1 hospital per county.... We could face the serious problems [sic] of having to transport patients at times up to 50 miles in order to obtain health care if a strike [occurs]."

While Taft-Hartley and state laws kept unionization in the health care industry relatively rare until the 1970s, NLRB rulings that watered down Taft-Hartley and then the NLRA amendments of 1976 helped increase collective bargaining agreements in hospitals from 3 percent in 1961 to 23 percent in 1976, after the NLRA amendments were passed.

Strikes' Effect on Patient Care

The mass California nurses' strike in September 2011 may have cost one woman her life, according to the California Nurses Association (CNA) itself. CNA claims the hospital hired poorly qualified replacement nurses who administered a non-prescribed dosage of a drug that resulted in the patient's death. The hospital denies any wrongdoing on its part, although it admits a nurse's error caused the death. CNA workers struck on September 23, which forced the hospital to call upon substitute nurses who signed five-day contracts. When the striking nurses wanted to return to work after a single day, they were barred. "Once a strike is called, it would be financially irresponsible for hospitals to pay double to compensate both permanent staff and replacement workers," hospital officials said.

While it remains unclear whether this strike led to the patient's death, the fact that strikes have negative effects on hospital care is undeniable. It is extremely unlikely that 23,000 full-time employees in any oc-

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cupation could be replaced in a single day without mistakes occurring—including serious ones. For example, Princeton University professors Alan Krueger and Alexandre Mas recently found that tires produced during strikes were 10 times more likely to have defects than those produced under normal working conditions. Given the extreme complexity and personalization of health care, it seems even more likely that similar mistakes would be made by replacement personnel, even if the replacements have the same or higher levels of skill as the personnel they replace.

It is reasonable, then, to conclude that strikes may kill more often than can be identified in clear cases of negligence, and empirical evidence exists to support this hypothesis. A major 30-year study found that strikes are, in fact, deadly. Jonathan Gruber of MIT and Samuel Kleiner of Carnegie Mellon University studied strikes by New York State nurses between 1984 and 2004. After controlling for factors like patient demographics and disease severity, they found that “nurses’ strikes increase in-hospital mortality by 19.4 percent and 30-day readmission by 6.5 percent for patients admitted during a strike.”

Gruber and Kleiner also noted that “patients with particularly nursing intensive conditions are more susceptible to these strike effects.” While the study fails to estimate the total death toll, it notes the types of mistakes that were made. For example, at Central Suffolk Hospital, “six medication errors were made, four of the replacement workers were sent home for incompetence, and...narcotics were missing in one department.”

The only other study on strikes by nurses looked at newborn patient outcomes at hospitals experiencing strikes in the Canadian province of Manitoba. Professor Cameron Mustard and his colleagues concluded in 1995 that “the pooled incidence of adverse newborn outcomes was significantly higher during the strike than during the prestrike period” and that this “is most plausibly attributed to disruption in the normal standards of care.”

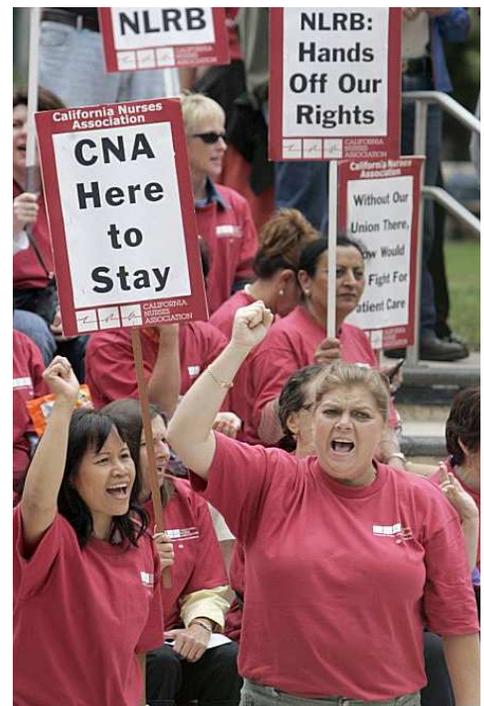
Such disruptions can be quite dramatic. In 1975, the year before Congress amended the NLRA to make nonprofit hospitals targets of compulsory unionization, a massive strike by service, maintenance, and laboratory employees unionized under state law forced 48 New York City area hospitals to discharge thousands of patients and close whole floors. Over 1,300 patients at local nursing homes were also sent home. The situation quickly became desperate as garbage piled up at hospitals. Worse, even as hospitals lacked resources to deliver medicine to patients, union picket lines blocked medical deliveries.

A similar strike in San Francisco prompted Congress to provide national standards, ostensibly to prevent such devastating health care crises, but the new standards failed to avert future strikes. As Sen. James Buckley (C-N.Y.) noted at the time, “This bill is an illusion. It offers the prospect of encouraging more disputes and hospital strikes, with the resulting loss of hospital services for the sick and the public in general.” Time has proved Sen. Buckley right. Today, all the same problems exist. When the Service Employees International Union (SEIU) struck 10 hospitals in San Francisco last July, for example, some hospitals had to cut services and transfer patients to unaffected facilities. Hospital representative Bill Gleeson told ABC News that he was “just hoping there isn’t a public health emergency.”

Unions Limit Care Through Price Increases

While health care unionization creates major problems for patients in the form of strikes, it has even more pervasive effects by increasing health care costs, which in turn limit patient care. Strikes are extremely costly. Hospitals must pay replacement nurses and additional security while losing business as patients opt for other hospitals. Last year’s strike by 600 D.C. nurses, for example, cost the hospital \$6 million. The 12,000 Minnesota nurses who struck cost hospitals about \$46 million for substitute nurses, and almost half of that was not for work, but for a day of mandatory orientation.

Mere threats of strikes can cost hundreds of thousands—even millions—of dollars.



Threats force hospitals to retain substitutes in advance for multi-day contracts. East Maine Medical Center in Bangor, for example, lost an estimated \$600,000 when it was forced to hire workers before an aborted strike. These costs exclude the additional negotiating costs involved in resolving the dispute. Even though a judge ultimately barred a planned strike by 10,000 University of California nurses, the hospital still spent \$10 million to \$15 million to fly in replacement nurses.

In multiple ways, collective bargaining and Department of Labor regulations increase health care costs significantly. Vanderbilt professor Frank Sloan studied the period immediately after the passage of the NLRA hospital amendments and found that unionization at 367 hospitals increased hospital labor costs by 8.8 percent without improving productivity. A second study by Dr. David Salkever of Johns Hopkins confirmed these results when his research showed that “unionization on average increases production costs by 5 to 9 percent.”

Unions often intentionally damage hospitals’ reputations in order to gain a negotiating advantage. “When you have something like this—when you have a group of employees knocking down the services of

their employer—you get factions within the community,” said Jill McDonald of East Maine Medical Center, who also noted that strikes decrease patient volume and hurt fundraising efforts: “People would say, ‘Well, I’m not going there while there’s a strike going on.’”

By increasing costs, the Affordable Care Act (ACA, also known as Obamacare) and other government interventions into the health care market have also created favorable conditions for unionization, thereby raising costs even further. For example, rising health care prices have led to a massive wave of consolidation in the industry, with 77 major mergers and acquisitions announced in the year after the ACA passed, the most in a decade. As hospitals struggle to cut costs, health care workers have a much more powerful incentive to vote for unions in the hope that collective bargaining will protect their jobs, benefits, and wages. Unions have won 4 to 17 percent more elections in health care than in other industries over the last decade.

In addition, health care’s large companies make inviting targets. As health care firms consolidate, they create much larger bargaining units, which gives powerful national unions more reason to spend time and money to bring in new members. Larger bargaining units also tilt the balance of power more decisively in the union’s favor. For example, replacing a few hundred employees is much easier than replacing tens of thousands of workers, as was necessary in last year’s Los Angeles strikes and the 2010 Minneapolis-St. Paul strikes. A 2009 Heritage Foundation study calculated that if U.S. health care becomes as unionized as in Canada, it would increase health care costs by \$27 billion in 2013 and \$192 billion in 2013-2018.

Unions Take Unprecedented Actions to Recruit Members

Union spending proves how favorable the union climate has become in health care. The California Nurses Association, for instance, has increased its annual spending by more than 300 percent since 2000, from \$15 million to over \$60 million in 2009, according to the U.S. Department of Labor.

In addition, over the last three years health care unions have

1. Essentially abandoned competing with each other for currently organized nurses, opting instead to focus on recruiting new members;
2. Spent millions of dollars to organize health care facilities in right to work states like Texas and Florida; and
3. Resorted to previously novel organizational methods, such as recruiting clergy to incorporate religious messaging into union campaigns.

Just as competition among hospitals has relaxed, so has consolidation become the norm among nurses unions. For many years, SEIU and the California Nurses Association competed fiercely for members, frequently accusing each other of harassment and “poaching” each other’s members. In 2008, the conflict even led to a physical confrontation between SEIU and CNA members at a labor conference. But in 2009, they “buried the hatchet,” according to Rose Ann DeMoro, president of the California Nurses Association. Then-SEIU President Andrew Stern said, “We spent a lot of time watching each other and at times competing with each other, and now we think it’s the right time to work together.” DeMoro agreed, adding, “We have a moment to seize.”

While the CNA was making peace with SEIU, it was adding tens of thousands of members by merging with United American Nurses and the Massachusetts Nurses Union to create a mega-union of over 150,000 members, National Nurses United. In its first press release, NNU announced its intention to “organize all direct care [registered nurses] into a single organization capable of exercising influence over the health care industry, governments, and employers”; it also pledged to “win health care justice: accessible, quality health care for all, as a human right.”

At the same time NNU was being organized, union bosses at the New York State Nurses Association’s Delegate Assembly

created the National Federation of Nurses (NFN) with eight other state nurses unions to represent 70,000 R.N.s across the country. Union leaders made the move without discussion with members or a vote. Judy Sheridan-Gonzalez, a New York City nurse and longtime union activist, and others faced disciplinary action when they pointed out how ironic it was that the NFN was created to be a contrast to the SEIU’s “top-down, undemocratic bureaucracy,” and yet “they go do the same thing—form these organizations, [and unilaterally] appoint the leadership.” A fellow nurse agreed: “It’s a page out of the SEIU playbook.”

Another indication of the favorable unionizing environment is the willingness of health care unions to try to recruit workers in right to work states. Right to work laws ban contracts between employees and employers that require every worker to pay union dues as a condition of employment. Nonetheless, the SEIU and CNA bet that once organized, enough employees will voluntarily contribute to the unions to make the unions’ cost of organizing worth it. The two unions also have a divide and conquer strategy. Their 2009 agreement decrees that the former rivals will work together to organize nurses under CNA, while organizing the rest of a hospital’s workforce under SEIU.

So far, the gambit seems to have worked. In just two weeks in 2010, SEIU and CNA organized more than 1,900 nurses in Texas. According to the Bureau of Labor Statistics, more than 80 percent of nurses pay union dues once organized, despite right to work laws, largely because of peer pressure to show union solidarity. With union dues typically around \$600 per year, those two weeks of organizing will bring in about \$910,000 per year to CNA. In Florida, SEIU Healthcare Florida voted in June 2010 to merge with 1199 SEIU United Healthcare Workers East. Afterwards they announced union dues would increase to 2 percent of gross income, with a cap of \$75 per month, to fund unionization efforts in the state and CNA/SEIU efforts elsewhere.

Finally, SEIU has resorted to using religious rhetoric against Catholic hospitals

that resist unionization. They quote papal encyclicals, which speak favorably about labor unions and “worker rights,” and use them against employers as part of their corporate campaign. In their battle with California’s St. Joseph Health System, for example, SEIU accused the Sisters of St. Joseph of Orange, who run St. Joseph, of having a “blind spot” on the issue of “social justice” they claim to support. The Sisters were the target of seven vigils organized by unions working with several left-leaning priests and nuns. Ultimately, SEIU prevailed.

Similarly, the National Union of Healthcare Workers (NUHW)—an offshoot of SEIU formed after an acrimonious 2009 split—accused sisters at Santa Rosa Memorial Hospital of “betraying Catholic social justice teachings by providing workers with misleading, anti-union propaganda.” One typical piece of propaganda is “Catholic Social Doctrine and Worker Justice,” a publication produced with the help of Labor Guild, a pro-union Catholic group. That the documents’ authors do not actually speak for the Church as a whole is never mentioned by SEIU or NUHW.

Only Getting Started

Unions have worked hard to create political conditions favorable to organize the health care industry. SEIU, for instance, spent about \$85 million during the 2008 election season, and it’s paid off, particularly for hospital unions. The Obama administration is committed to tougher enforcement of union protections. Department of Labor Solicitor Patricia Smith has said, “Many employers developed a ‘catch-me-if-you-can’ attitude. Our challenge is to change that attitude.”

Meanwhile, the NLRB has handed unions several important victories. First, it decided to allow a pair of 16 foot union banners at two Arizona medical centers that proclaimed “Shame!” even though the targeted employer was a contractor, not the centers themselves. Then, in a decision leveled against a nursing home in Alabama, the Board decided to allow “micro-bargaining units,” which let even very small groups of workers organize. Ac-

ording to data from the NLRB, the smaller the bargaining unit in a union election, the higher the win rate for unions.

The NLRB has also decided to allow “ambush elections,” which take place just days after a union files a petition for a representation election. This change could shrink the median timespan from petition to election by 17 days, from 38 to 21 days, and in some cases as little as 10 days, according to analysis by IRI Consultants. This gives employers almost no time to make their case to employees. In combination with micro-bargaining units, this decision is even more challenging for hospitals, because a handful of employees could organize quickly, petition, and hold an election without warning in just days. Other recent NLRB decisions have banned pre-election appeals and limited pre-election hearings to only whether an election should be held (rather than what the effect of the union will be on workers). All of this will make it even more difficult for hospitals to stop union expansion.

Conclusion

The object for unions isn’t patient care or even workers’ rights. It’s money. Each new member means income for union bosses. That’s why they pushed California lawmakers to institute required nursing staff ratios to artificially increase their membership. That’s why they have invested in right to work states. That’s why they continue to spend millions of dollars on elections and on organizing. That’s why they will never consider the effect their strikes, regulations, and enormous benefits have on patient care and health care costs.

Unfortunately, the people who bear the cost of this drive to unionize are the people that most health care workers went into their profession to help. Florence Nightingale, the founder of modern nursing, once said, “It may seem a strange principle to enunciate as the very first requirement in a hospital that it should do the sick no harm.” The same can be said of health care unionization.

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LaborNotes

Surprise! Labor unions actually spend a lot more on politics than previously reported. A *Wall Street Journal* analysis on political spending by organized labor revealed these groups spend about four times as much on politics than generally thought. While previous estimates focused solely on labor unions' reports to the **Federal Election Commission** (FEC), which counts money given to political candidates at the national level, the *Journal's* new analysis also counted political spending that unions report to the U.S. **Labor Department**, which includes spending in support of state and local candidates, lobbying efforts, and raising voter awareness. Unions' reports to the FEC show political spending totaling \$1.1 billion from 2005 through 2011, but separate reports to the Labor Department show unions spent an additional \$3.3 billion over the same period, for a grand total of \$4.4 billion. Now if we only knew how much unions spend on politics without reporting it.

Speaking of unions and politics, another *Wall Street Journal* report shed light on the political agendas of America's two largest teacher unions, the **National Education Association** (NEA) and the **American Federation of Teachers** (AFT). Again looking at political contributions reported to the Labor Department, the *Journal* found the two unions' political spending totaled more than \$330 million from 2005 to 2011. The spending takes many different forms but it goes almost exclusively to Democratic candidates and left-wing causes. Donations include \$400,000 from the NEA to radical pressure group **ACORN**, \$250,000 from both unions to **Al Sharpton's National Action Network**, and \$45 million in contributions from the NEA for the 2008 state and federal elections, where more than 90% was lavished on Democratic campaigns.

What do unions do when they're angry with the political party that they shower with donations? According to union leaders, the only logical solution is to hold a "shadow convention." The Associated Press reports that union leaders plan to hold their own convention in Philadelphia on August 11, to promote labor issues they feel party officials are slighting. More than a dozen unions have announced plans to boycott the Democratic National Convention, which will be held in North Carolina, a right-to-work state.

The July jobs report from the Department of Labor brought more bad news for Americans, with a mere 80,000 jobs created in June and unemployment rates sticking at 8.2 percent. Despite these pitiful figures, the President wasted no time in declaring that June's job figures were "a step in the right direction."

Pat Santeramo, former president of a Florida teachers union, was arrested on July 10 for multiple criminal charges related to conduct within the union, including theft and fraud. According to reports, Santeramo diverted as much as \$165,000 from the **Broward County Teachers Union** (an AFT affiliate) between 2001 and 2012. Santeramo is also accused of making illegal campaign contributions by reimbursing union members with union funds for their supposedly personal campaign contributions. Candidates receiving such contributions include former U.S. Presidential candidate **Hilary Clinton**. Santeramo, a former physical education teacher, took over the union's presidency in 2001 after **Tony Gentile** was forced out of the position following his arrest on charges of engaging a minor in an online relationship.