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Health Plans and Collective Bargaining, by Joseph W. Garbarino

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HEALTH PLANS AND COLLECTIVE BARGAINING. By Joseph W. Garbarino. Berkeley and Los Angeles: University of California Press. 1960. Pp. xi, 301. \$5.00.

The title of this book, a publication of the Institute of Industrial Relations of the University of California, reveals its major focus. The author is Associate Professor of Business Administration and Associate Research Economist, Institute of Industrial Relations, University of California at Berkeley. Among the several strands of the network of plans for developing private health insurance, health plans negotiated by union representatives in collective bargaining are one of the most interesting and significant. Between 1946 and 1957 the number of workers covered by health insurance under collective-bargaining contracts increased from less than a million to more than 12 million with perhaps another 20 million dependents—in all about one-sixth of the population. Of even greater significance is the fact that while Blue-Cross-Blue Shield and private insurance company plans serve almost entirely as a mechanism for financing medical care, collective bargaining plans introduce a new element. Under collective bargaining plans, powerful economic organizations, the unions, serve as representatives of consumers of medical services, and interest themselves not only in financing medical care, but in the structure and functioning of the medical “industry” itself. The

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impact of negotiated plans upon prevailing arrangements for providing medical care is the major concern of the study and the bulk of the book describes and analyzes the development of health plans under collective bargaining in the San Francisco Bay Area from the end of World War II to 1957.

Although the California experience in the development of negotiated plans for health insurance is unique in some respects, the usefulness of the book is by no means regionally limited, nor indeed limited to the student of collective bargaining. Garbarino has devoted several chapters to broader issues and is very effective in emphasizing those problems involved in providing medical care through insurance or prepayment plans that are likely to arise in any large program, private or public. Indeed, the book is highly worthwhile for anyone with a serious interest in the reviving discussion of compulsory governmental health insurance programs.

The book concludes with a summary chapter organized around a series of propositions or conclusions that the author draws from the body of his study. The inclusion of hospitalization and medical care benefits on the agenda of collective bargaining has brought under health insurance large numbers of workers who would not otherwise have been covered. Negotiated plans have also affected the scope of health insurance coverage in other ways. There has been constant pressure for the inclusion of more items of medical care. Physical examinations, maternity care, home and office visits, even dental and psychiatric care are either already included in negotiated plans or under active consideration for future demands. Unions and employers have also influenced the "depth" of health insurance by constant pressure to raise benefit schedules and "systematically testing the protection afforded by health insurance against the actual need it is designed to meet." (p. 251). A recent study by the United Steelworkers of the medical care plans it has recently negotiated, illustrates Garbarino's points. The union states that its goal is "to achieve for its members and their families comprehensive health care of high quality, fully prepaid, adequately financed but economically operated, and available to all workers when actively employed, laid off or retired and to all their dependents."¹

The drive for more comprehensive medical care programs raises a policy issue which is vitally important in broad discussions of health insurance. Advocacy of complete medical care, whether under a service plan or an indemnity plan—and a choice between these two is another

1. AFL-CIO, *Collective Bargaining Report*, Vol. 5, No. 7 (September 1960).

important issue—encounters opposition from those who stress the *insurance* aspects of health insurance. In this view the purpose of health insurance is to cover the costs of the cancer operation, but not those of the common cold. Thus there is a rising emphasis on deductible amounts, corridors and co-insurance. Despite the obvious economies in costs achieved by these features of health insurance plans, they will be bitterly opposed by labor groups who believe in comprehensive coverage as a matter of principle. Closely associated with consideration of the expansion of medical care problems is the very important matter of the nature of the supply of medical services. If this supply is limited as is commonly assumed and is relatively inelastic as seems probable, increases in the effective demand for medical care engendered by significant expansion of health insurance has and will produce significant pressure on the costs of medical services.

Garbarino discusses at some length some of the specific questions implied by the last comment. He carefully reviews the evidence for the proposition that the extension of private health insurance has raised fees for medical services and charges for hospitalization and finds its unconvincing with the possible exception of the case of hospital daily rates. Much more important than the impact on medical prices has been the inflationary impact of health insurance on medical costs. The cost impact of “abuses” of health insurance—false claims, unnecessary hospital admissions, excessively prolonged hospital stays, unnecessary surgery, visits to the doctor, etc.—is substantial even when only a minority of physicians is involved. If the remedy of deductibles and co-insurance is to be avoided, the signs point clearly to more active regulation of certain aspects of medical practice on the part of medical organizations, insurance companies and the consumers of medical care. Obviously, the prices of medical services will occupy a prominent position in any discussion of the control of abuses of health insurance.

As previously indicated, the development of health plans under collective bargaining has created an organized consumer interest in the structure and functioning of the supply side of the medical market. In the San Francisco Bay Area, local union groups have tried to establish more-or-less formal collective bargaining relationships with medical societies that would establish binding fee schedules; health centers under union control to provide medical services directly have been seriously proposed; they have tried to assemble panels of doctors to service their members by contracting with individual physicians; and they have participated in and supported attempts to modify the usual form of medical practice, chiefly the Kaiser Foundation Health Plan, a system of pre-

paid medical care offering comprehensive coverage on a service basis. The detailed account of all these developments is of itself an interesting story. Of even greater interest is the speculation which it stimulates as to the impact of further substantial expansion of health insurance whether private or public upon medical economics.

The voluntary health insurance movement, of which collectively-bargained health plans are an important part, has been defended as a desirable substitute for a compulsory governmental program. Important groups in the economy, notably the medical profession and private insurance companies, are committed to making this substitute work well enough to avoid the necessity for a comprehensive governmental program. Negotiated plans may contribute to this objective, but cannot be expected to guarantee its attainment. As Garbarino points out, the extent of collective bargaining itself appears to have approached limits that are far short of complete coverage of the labor force. He concludes that even when all forms of private health insurance are combined, the great growth of these programs "does not appear to have provided a medical care system that can forestall a substantial expansion of governmental participation in the distribution of medical care, at least for certain classes of the population and possibly to some extent for most of the population." (p. 279). On the other hand the growth of private health insurance means that governmental health insurance will not monopolize the field.

An important and challenging question for the future is therefore the respective roles of private and governmental programs in the provision of medical care; and, given the continued development of private plans in general and collectively-bargained plans in particular, the kinds of modifications and innovations that will emerge in the structure and performance of the practice of medicine.

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THE ANTITRUST LAWS OF THE UNITED STATES OF AMERICA. By A. D. Neale. New York: Cambridge University Press, 1960. Pp. xvi, 519. \$7.50.

This volume on American antitrust law is written for the British reader by a British civil servant. In spite of or perhaps because of this, it is a notable contribution to antitrust literature and should be of interest

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