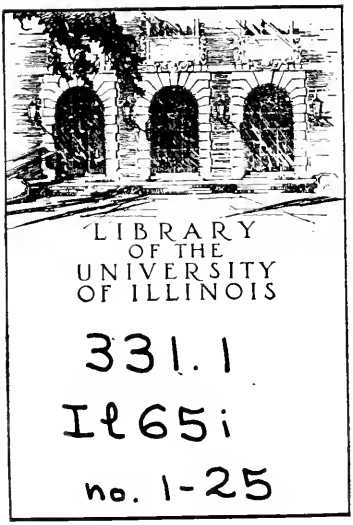

Health Programs In Collective Bargaining

INSTITUTE OF LABOR AND INDUSTRIAL RELATIONS

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EDITORIAL NOTE

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HEALTH PROGRAMS IN COLLECTIVE BARGAINING

By John M. Brumm

AGREEMENTS BETWEEN UNIONS AND EMPLOYERS TO PROVIDE "health benefits" for industrial workers are now a well-recognized development in industrial relations in this country. More than 3 million workers by the summer of 1948 were covered by "some type of health, welfare and/or retirement benefit plan under collective-bargaining agreements," according to estimates recently announced by the Bureau of Labor Statistics of the U.S. Department of Labor.[1] This was more than double the estimated number of employees covered by such plans in early 1947. Decisions by the National Labor Relations Board have indicated such benefits are one of the legitimate objects of collective bargaining, under the Labor Management Relations Act, 1947 (Taft-Hartley act).

This bulletin will describe the main features of current health benefit plans and discuss some outstanding problems and issues. The discussion is designed to give interested persons a general outline of the subject. For those especially concerned with the practical problems of developing a health program, the bulletin offers aid and suggestions for obtaining necessary additional information and guidance. It cannot be overemphasized that health plans raise some very vital and highly complex problems for both unions and employers. The specialized knowledge of several different professions is needed to solve these problems, depending on the type of program desired and the stage of its development. Experts who might be consulted, for example, are those in the fields of general medical economics, public health, medicine, law, social welfare administration, insurance, and industrial relations.

This discussion is devoted exclusively to "health benefit programs." This is only one aspect of the "health and welfare funds" used by unions and management to establish some of these kinds of benefits for industrial workers: life insurance, retirement pensions, general health care. Each of these benefits presents a distinct set of considerations and problems. Here we shall consider that part of a "welfare fund" which is used to pay for benefits for workers and

[1] "Benefit Plans Under Collective Bargaining," E. K. Rowe and A. Weiss, *Monthly Labor Review*, September 1948.

their dependents in connection with non-occupational injury or illness. The benefits may compensate for loss of wages when disabled or help make available needed hospital and medical services.

TRENDS IN HEALTH PROGRAMS

This recent trend toward including health plans for employees in union-management agreements is usually considered by the unions to be one phase of the general effort of organized labor to cope with the common kinds of insecurity facing workers and their families in an industrial society. The Social Security Act and state workmen's compensation laws provide some degree of protection against unemployment, death of a wage earner, dependent old age, as well as against job loss, incapacitation or other results of work injury. Only three states, however, (Rhode Island, California, New Jersey) have set up systems granting limited benefits to workers in connection with non-occupational illness or injury. Federal legislation of this kind currently applies only to railroad workers, who first began to receive benefits in July, 1947.

"Health insurance" or "health benefit programs," as these terms will be used here, include disability insurance (commonly called "sickness and accident") which is designed to protect individual employees against the loss of wages due to disabling illness or accident; and medical care insurance which is designed to protect employees against the costs of physician, hospital, medical, and other related services in connection with illness or accident.

Workers are interested in these plans because they want protection against the burden of these unpredictable expenses and losses of income. Most workers cannot provide in their budgets for such costs, which cannot be predicted either as to amount or frequency of occurrence. Health insurance thus can relieve the individual of financial worry in connection with illness and help provide adequate care for illness.

Favorable attitudes of employers towards health insurance for employees have been based on claims that such programs are capable of: **1.** reducing absenteeism, **2.** decreasing the turnover rate, **3.** protecting against physical deterioration of employees which would lower productivity, **4.** protecting against

recurrent conditions which increase workers' susceptibility to industrial accidents and diseases, 5. providing insurance against the high cost of replacement of skilled and experienced employees lost by early death or forced into retirement by poor health, and 6. improving plant morale through employees' increased sense of security.

Impact of World War II

Records indicate that the first collective bargaining agreement to provide for non-occupational sickness and accident benefits was negotiated as early as 1926, but the new trend did not emerge clearly before World War II. During the war the wage stabilization policies of the War Labor Board effectively restricted union bargaining for simple across-the-board wage increases even when employers were ready to grant them. Most health insurance plans negotiated during the war were the result of efforts to discover benefits in lieu of wages which the War Labor Board would approve and which would have an obvious value for workers in dollars and cents and in improved morale. Paid vacations and paid holidays were the most popular of these wage-substitute demands. They were widely established by the end of the war in union-management contracts. Health insurance was never as common an item in negotiations. The Board never seriously considered disapproving these insurance arrangements, when agreed to by both parties, but it did not order their inclusion in contracts in disputed cases.

Consequently, during the war the government made no official determination of the status of health insurance among collective bargaining demands. The question arose again under the Labor Management Relations Act, 1947. In the early fall of 1948 a U.S. Circuit Court of Appeals upheld a National Labor Relations Board ruling requiring an employer to bargain on pension plans. The court held that the terms "wages" and "other conditions of employment" as used in the collective bargaining provisions of the Act clearly include pension and retirement funds. The NLRB, in another case, ruled that group health insurance plans also fall within the meaning of these terms. The issue has not yet been ruled upon by the Supreme Court.

Plans Found in Many Industries

Health benefit plans of some sort are now found fairly frequently in collective agreements in the following industries: coal mining, men's and women's clothing, millinery, textile and hosiery, local transportation, upholstering, furniture, machinery, rubber, paper, fur and leather, retail and wholesale trade, cleaning and dyeing, hotel and restaurant, telephone and telegraph, and some sections of the building trades. There are probably few industries in which they are not found at least occasionally.

The establishment of health benefit plans in collective agreements is a recent development, but the concern of employers and unions with problems affecting the health of workers is far from new.

In the formative period of the American union movement the constitutions of many unions provided for benefit payments to members in certain emergencies, such as death or permanent disability. Such plans were financed entirely by union members, through dues or special assessments. Only a few of them provided benefits in the event of sickness. After World War I rising benefit costs, financial instability due to depression, and other economic causes led many unions to revise or terminate these self-financed programs. In 1908, 18 national unions financed sickness and medical benefit programs from their own funds. By 1935, this number had dwindled to seven. Moreover, these benefits were frequently regarded as a member-getting and member-holding device rather than as a part of a planned health security program.

On the employer side, companies frequently have provided their employees with medical service programs of varying degrees of comprehensiveness or have sponsored commercial group insurance plans. These plans have been both with and without employee participation in the costs. Many of the medical-service type provide a high quality of service and have been run successfully for many years.

Character of New Programs

Current health benefit plans set up as a result of employer-union negotiations differ in several respects from most of the earlier plans sponsored solely by unions or by companies. First, since the

plans are part of the contract, they affect all workers covered by the contract. Second, they are financed entirely, or in large part, by the employer. Any funds involved are usually administered jointly by the union and employer. In the third place, where a previously existing employer-sponsored plan has been incorporated into the contract, benefits have usually been increased. Finally, benefits are uniformly considered as the "right" of a covered employee as soon as his disability or medical expenditure has been verified.

The occurrence and duration of individual illness is unpredictable. But it is quite possible to estimate and measure the incidence, frequency, severity, and duration of illness and the resulting costs of adequate medical care for large groups of people. Health insurance is built on this principle. The essentials of a health insurance program include pooling the risks of illness of many people, spreading the costs over the group, and prepaying costs regularly and periodically, on the basis of the average-estimated-cost per individual. Establishing an insurance plan, therefore, requires enough people to join together to share the risks of future illness; and sufficient funds paid into the plan at regular intervals to meet all the costs which the plan is designed to cover.

Voluntary health or medical care insurance, as it is frequently called, has been developing in this country over several decades. The term "voluntary" commonly applies to those plans which groups of people establish or which they join as members. On the other hand are those health programs which apply more broadly, such as public health programs and national health insurance created through legislation. When a union and employer establish a health benefit plan in their contract, they normally make a selection from among the different kinds of existing voluntary plans. They may wish to purchase group health insurance policies from plans available to groups of employees over a wide geographic area, or they may wish to subscribe to services provided only to employees in a restricted locality. To understand the characteristics of health plans in collective bargaining requires, therefore, an analysis of the different voluntary plans. The basic character of a voluntary plan is not affected by the fact that collective bargaining has brought a certain group of workers under its protection.

UNDERSTANDING HEALTH PROGRAMS

There is no simple, single classification of health plans. The most helpful way of understanding their many variations is to look at each plan from five different points of view: 1. control, 2. type of benefits, 3. eligibility for benefits, 4. scope or extent of benefits, and 5. standards of medical services.

Control

With respect to control, health plans fall into two groups: those developed by commercial insurance companies as business undertakings, and those formed as non-profit organizations by groups of physicians, groups of hospitals, groups of individuals who intend to receive the medical care (such as those in a cooperative), fraternal societies, joint union-employer funds, governmental agencies, and others. Commercial company plans usually are designed to insure against a limited number of health needs. Non-profit plans, on the other hand, vary widely. Some cover only a few health needs, while others attempt to meet a wide range of needs.

Type of Benefits

Employees covered by a plan may receive benefits in the form of *cash indemnity* (money) or *services rendered,* or a combination of both. Commercial companies normally use the cash-indemnity approach, while non-profit organizations may use either the indemnity or the service approach.

Under cash-indemnity plans the employee is reimbursed for specific expenses and losses due to accident and illness, according to a definite schedule of benefits spelled out in an insurance policy. He may be compensated for part of the loss of wages during illness by "disability benefits." He also may be reimbursed for his hospital bills by "hospital-expense indemnity" and surgical bills by "surgical-expense indemnity." In any case, the patient must first pay out of his own pocket his bills for doctors, hospitalization, surgery, medicines, and other charges. Then when he has proved disability and presents the paid bills, he receives cash payments in accordance with a schedule which sets up maximum benefits. Indemnity-type payments may be provided under commercial or non-profit auspices.

They are designed to relieve the worker of part of his sickness expense.

Service plans, on the other hand, are organized to furnish one or more specific services necessary to restore or maintain health. When in need, the subscribers may receive doctor's care, surgical operations, hospitalization, and other services without paying for them directly. Payments are made by the insurer, usually a nonprofit organization, to those who provide medical service. For example, the Associated Hospital Service of New York, as an insurer, pays charges incurred by its members directly to the hospitals participating in the plan.

Many plans have both service and indemnity features, which sometimes make them difficult to classify. A typical Blue Cross plan, for example, may provide hospitalization in a semi-private ward for 21 or 30 days per year. This is a service program. An indemnity feature is added if the plan also provides for cash reimbursement at a fixed daily rate when a private room is chosen. Service plans do not pay disability benefits for the loss of wages.

Eligibility for Benefits

Eligibility to join health insurance plans is frequently restricted. Individual enrollment may not be permitted. Groups, to be eligible, may have to include more than a certain minimum number of people. Certain restrictions based on age, occupation, income, or physical condition may be imposed on individual members.

Plans established in union-employer contracts usually permit few if any restrictions and tend to apply equally to all employees within the bargaining unit of an employer or group of employers. Weekly disability-indemnity benefits may vary according to the employee's earnings, and quite frequently there is a requirement that an employee be employed one month or more before being included in the plan. In addition the trend appears to be to extend coverage to dependents of employees for at least some of the benefits.

Scope of Plan

The amount of cash benefits or medical services provided by a plan determines to a large degree the effectiveness and the cost of

a plan. A plan may be limited to a single type of benefit for employees only, such as hospitalization on dental care. At the opposite extreme a plan may be comprehensive, providing employees and their families with almost all necessary medical services. These may even include preventive medicine, thus making it possible for the insured person to consult doctors for general health advice, for periodic physical examinations, for diagnostic check-ups, and for check-ups after an illness. Most plans, however, fall somewhere between these two extremes. Some are limited to cash benefits or specific services in connection with disabling illness. Other programs cover all "common" medical requirements of the worker and his family.

The scope of a plan may be limited in many other ways. Indemnity plans frequently set up a minimum waiting period of illness — usually three to seven days — before eligibility for a given benefit begins. Benefits may run for a definite period of time and then stop altogether, or continue on a reduced basis. Benefits may be payable only for specific kinds of illnesses — those requiring surgery, for example. On the other hand, certain illnesses, such as mental diseases, may be omitted from an otherwise comprehensive coverage. In some plans, notably those provided by commercial insurance, benefits are limited to *disabling* illnesses and accidents, that is, illnesses and accidents which keep the employee from performing his work. Most hospitalization plans which also provide laboratory and other services usually restrict these extra services to hospitalized cases only. Other kinds of restrictions on the scope of benefits are imposed by other plans.

Standards of Medical Services

A highly important aspect of any serious effort to meet the health needs of a group of employees is the quality of hospital and medical care they can obtain. Indemnity plans do not attempt to deal with this problem. Hence covered employees receive that standard of hospital and medical care which is available to them in the community in which they live, depending, of course, upon their willingness and ability to make use of it. Service plans, on the other hand, being directly responsible for medical service for their members, frequently emphasize the quality of those services. Standards of service may be set for participating hospital and physi-

cians. New facilities, such as clinics, hospitals and laboratories, may be directly organized by the plan. The services of participating physicians sometimes are also organized in such a way that general practitioners and specialists work together as a group, often under one roof, thus combining their knowledge and skill and their technical personnel and medical equipment — a method known as "group practice." Standards of health also are controlled by some plans by providing for early diagnosis of conditions leading to illness, for "preventive" medicine, and for the education of employees in good health practices.

NEGOTIATING HEALTH PROGRAMS

After employers and unions have agreed to some sort of a health program, they face three distinct sets of problems: 1. what kind of a program to select, 2. how to write the agreement into the formal contract, and 3. how to handle the financing of the plan.

Broadly speaking, the parties to the agreement have the choice of providing health benefits under a scheme developed by one of the parties or by both parties working together, or through subscribing to some existing plan which is available in the locality where the employees work.

Specially Organized Plans

Plans organized by the parties themselves may provide cash indemnity or service benefits. Cash indemnity benefits — disability, hospitalization, surgical — are sometimes paid directly from a union-employer-controlled fund like that provided in agreements between the United Hatters, Cap and Millinery Workers (AFL) and their employers in several cities. Another variation in this "self-insurance" is seen in the men's clothing industry. A capital-stock insurance company, chartered under the laws of New York State and governed by a board of directors composed of union and employer representatives, issues cash indemnity policies to eligible members of the Amalgamated Clothing Workers of America (CIO) who work for clothing manufacturers having collective-bargaining agreements with the union.

Service programs organized specifically for a group of employees covered by management-union contracts can take several

forms. A "complete" program of this type would require: 1. contracting for the medical services of a panel of general practitioners and specialists, for home, office, and hospital practice; 2. ownership of a hospital; 3. establishment of a clinic with diagnostic and therapeutic facilities. In practice, however, one of the above three elements in a "complete" program may be combined with other arrangements. An example is the St. Louis Labor Health Institute, supported by contributions provided for in contracts between the United Distribution Workers (formerly CIO, now independent) and St. Louis retailers and wholesalers. This plan provides two of the three elements, but buys hospitalization for covered employees through the local Blue Cross plan. In the women's garment industry in some cities the Union Health Centers of the International Ladies' Garment Workers' Union (AFL) provide many clinical services. Most of the other aspects of these programs are handled on an indemnity basis.

Plans Already Available

Indemnity or service programs already are set up in many communities and new groups of employees may be included in them. These existing plans fall into five principal categories: 1. commercial insurance indemnity plans providing policies fairly well standardized among companies, which may be purchased separately or combined in "packages"; 2. Blue Cross or similar hospitalization plans organized by hospital associations; 3. cash indemnity or service plans providing surgical benefits, and sometimes including other (non-surgical) medical benefits, which are sponsored on a non-profit basis by local or state medical societies; 4. group-practice plans controlled by physicians, which frequently provide comprehensive services; 5. group-practice plans controlled by consumers (that is, by the subscribers to the plan) or by other arrangements. Such plans place different degrees of administrative responsibility in the hands of non-medical persons.

It is not the purpose of this bulletin to suggest the standards by which a plan might be intelligently selected to fit particular circumstances. Many experts, agencies, and organizations are available for consultation on such questions. It is important to

give careful consideration to all available alternatives and to seek competent advice.

Group Needs and Services

Here is a check-list of the kinds of basic information which unions and employers will find essential to collect as a preliminary step in planning any health program:

1. Size of the employee group to be covered and its normal average earnings.

2. Composition of the group according to sex, age, and marital status.

3. Special health needs of the group.

4. Geographical concentration of the group.

5. Hospital and medical facilities available in the community.

6. Costs prevailing in the community for hospital services, common surgical operations, and physicians' home and office visits.

7. Number of physicians in the community and the possibilities for group medical practice.

8. Premium costs and benefit provisions of standard commercial group insurance policies available in the region.

9. The services provided and rates charged by all service plans in the locality such as health cooperatives, hospital associations, medical societies, and associated physicians.[1]

Union-management health plans have followed no definite pattern. They combine different kinds of benefits in many ways. The majority of these plans have in the past emphasized the cash indemnity approach, but the trend is toward increasing use of other methods. As seen by the authors of a recent Bureau of Labor Statistics study: "The present tendency is to increase the number

[1] The following references will be useful in finding what plans are available in a given area and the kinds of benefits offered:

Blue Cross Contract Guide, Hospital Plan Commission, 18 E. Division Street, Chicago 10, Ill.

Prepayment Medical Care Organizations, Bureau Memorandum No. 55, Bureau of Research and Statistics, Social Security Board, Washington, D.C.

Voluntary Prepayment Medical Care Plans, American Medical Association, 535 North Dearborn Street, Chicago 10, Ill.

of different benefits provided, as well as to liberalize existing benefits. Medical services, particularly of a preventive nature, . . . are currently receiving special attention."[2]

From the point of view of the union, which today normally initiates the insurance proposal, these plans are negotiated in several ways with employers, with associations of employers, on an industry-wide basis, regional basis, or local basis. Some national and international unions sponsor a uniform plan which they attempt to have written into all the local union contracts. Other national unions give information and assistance to their local and regional bodies in bargaining on this issue. Some unions have created specialized "social security" or "welfare" departments, staffed by technical experts, to assist in developing health and other types of welfare programs.

Issues in Bargaining

Both employers and unions are more inclined now that earlier to consider the selection, operation, and improvement of a health program as primarily technical problems which can be dealt with effectively only in the light of the best information available. Hence, the question may be raised: Where do the collective bargaining aspects of health programs end? Where do the "technical" problems begin? The experience of the parties in industrial relations will probably suggest answers.

In the negotiations, the main issues may be the amount of employer contribution to the program and the participation of employees in the costs. Occasionally the plan itself may be chosen during negotiations and a decision reached to write it into the contract. This is particularly common when a commercial insurance plan is chosen and the employer agrees to buy directly from an insurance company policies with specified benefits. In some contracts clauses go into considerable detail. In others, the parties limit themselves to a few general clauses. This approach is said to permit a desirable flexibility in setting up the plan best suited to the conditions and in meeting future problems. Where detailed provisions are thought desirable, as in the case of setting up a trust fund, the necessary documents can be drawn up as a supplementary

[2] *Benefit Plans Under Collective Bargaining,* previously cited.

agreement after the basic contract has been signed. A special management-union committee also can be created with powers 1. to investigate available health programs, 2. to recommend a plan, 3. to work out the details of the plan selected, and 4. to suggest later modifications of the plan, within the limits of the basic contract.

Writing the Contract Terms

The principal items usually included in the basic contract are a statement of the decision to set up a plan and certain arrangements in connection with its financing and administration. Clauses dealing with financing and administration usually state the basis on which contributions to the program are to be computed, and the organization or fund to which payments are to be made.

Some union-management bargaining committees, because of particular circumstances, have also found it worth while to write other provisions covering such points as:

1. Conditions governing the coverage of present and future employees and coverage of employees transferring from one employer to another.

2. A board of trustees or other body to handle a health fund, with a statement defining the duties of this body and safeguarding the fund against possible diversion to other than employee welfare purposes.

3. Method of collecting and compiling statistics of the health plan in operation, which can be used to guide future decisions.

4. Procedures to settle any disputes arising between the parties and to handle complaints of employees about operation of the health program.

5. Procedures for easy adjustments of the plan to possible future legislation in the health field.

Financing the Program

The method of financing health plans takes several forms. The employer may handle the entire cost through contributions to a special fund or by outright purchase of policies. The union may contribute to the cost, or a percentage of the cost may be met by the employees through regular wage deductions. The present trend

among plans created under collective bargaining, according to the B.L.S. study referred to earlier, is "toward complete financing of the plan by the employer, or toward lowering the employee's share in a contributory plan."

Several different bases for determining employer contributions are used: per capita, percentage of payroll, percentage of sales revenue, lump sum, "tax" or "royalty" on production. The nature of the industry and anticipated economic conditions are undoubtedly considered by unions and managements before deciding upon the method of financing. A seasonal industry, for example, will have different problems from one with regular employment and a low rate of turnover. There is, of course, no customarily established amount for an employer contribution. This question is obviously determined by many factors in the total collective bargaining relationship, as well as by the comprehensiveness of the health program which the parties want. At present, employer contributions normally vary between 1 and 5 per cent of the payroll, with the average probably between 2 and 3 per cent.

HOW A HEALTH PROGRAM WORKS

In discussing health plans under collective bargaining the term "administration of the plan" is frequently confused among three different things: 1. Administration of the actual operation of the plan — paying benefits or providing services; 2. Administration of a fund earmarked for health insurance; 3. Handling of day-to-day details such as processing of claims or dealing with complaints.

Operating the Plan

Usually the administration of plan operation (1. *above*) is very distinct from the administration of a fund (2.). Under most commercial indemnity plans, Blue Cross and Medical Society contracts, and group-practice plans, the insurance company, hospital, or other association is the administrator of the *plan,* while the union or the company (or both) may administer the *fund* out of which premiums are paid or subscriptions purchased. There are, however, instances in which the two functions are merged. For example, the trustees of a fund may share in the administration of a commercial insurance plan; they may accept claims, process them and pay out the

benefits on behalf of the insurance carrier. Or, benefits may be paid directly from the fund to the beneficiaries without the intermediary of any insurance company. This latter method implies the prior accumulation of reserves to assure the solvency of the fund.

Administering the Fund

Establishment of a fund is often considered an efficient and flexible method of handling all moneys earmarked for health purposes. It permits the contracting parties to change the plan. It also makes possible the accumulation of a reserve which may be used to expand the original program, especially when large capital outlay is desired (as, for example, in building a clinic).

Before passage of the Taft-Hartley Act, the trustees of union-management health funds were composed of 1. union representatives alone, 2. union and employer representatives (equally divided or with union members in the majority), or 3. representatives of the union, management, and some outside community group or agency.

Under the present law, however, all health fund arrangements set up after January 1, 1946, must be administered by boards which have equal representation from union and management and include provision for settling of deadlocks by some neutral party.

Day-to-Day Details

The third aspect of "administrative" problems involves handling certain day-to-day details such as processing employees' indemnity claims. These claims are handled through union offices, employer offices, or by the insurance company. Under any arrangement problems arise in connection with procedures for filing claims, requesting services, routing payments, and informing employees of their benefit rights. Active participation in these procedures by the union or employer often is necessary to make them work smoothly and efficiently. Many workers may fail to get what they are entitled to if they are not informed about their rights under the program and how to use available benefits. Many parties to collective bargaining contracts have discovered the value of establishing a "complaint office" where employees can come for information and advice. This office can correct misunderstandings, improve the efficiency of procedures, and eliminate possible injustices.

Differences may also arise between union and employer over the interpretation of the collective bargaining contract; between union or employer and carrier company over proper application of the terms of an indemnity policy; and between union or employer and service plan over the medical services. Many unions and companies, therefore, have found it advisable to establish formal procedures for settling these disputes. Such machinery helps establish fair and consistent policies.

Sometimes doubt may arise whether a specific illness or accident is subject to the state workmen's compensation law or is "non-occupational." In order to keep such confusion from delaying medical care or cash benefits, health benefits are sometimes granted pending final determination of any doubtful case.

Legal Problems

State laws, of course, have a direct bearing on health plans which unions and employers can establish. In certain states laws may definitely limit the alternatives available to the contracting parties, and in other states laws may help them carry out their objectives. Adequate legal advice, therefore, is an early necessity, particularly in establishing funds and in organizing group-practice plans.

EVALUATING HEALTH PROGRAMS

Cost is a crucial consideration in evaluating any plan. Costs vary depending on the geographic area or the type of plan. The many differences in health programs make costs difficult to compare. In addition, accurate and worth-while comparison is complicated by the fact that the "true" cost can be determined only by a study of the plan in operation over a period of time. In other words, it is not merely the per capita cost of a plan for specified health benefits that counts. More important is this cost in relation to total benefits actually received by the entire group over a given period. Hence, the extreme importance of keeping complete records of a plan as it runs from year to year. In his book *Voluntary Medical Care Insurance in the United States,* Dr. Franz Goldmann summarizes the over-all problem of evaluation in this way:[1]

[1] Columbia University Press, 1948. Quoted by permission.

The factual knowledge which is the key to the evaluation of voluntary medical care insurance may be obtained in various ways. Intensive field studies of plans of various types may be made or pertinent information may be gathered by questionnaires. Material published in folders, bylaws, and annual reports may be analyzed. Statistical data on plans similar in type of provisions and method of organization may be collected, computed, and studied. The opinions of the people receiving service, of the participating professional persons and hospitals, and of the administrators may be ascertained by personal interviews or correspondence.

In actual practice all these methods have been employed separately or in varying combinations. The best results can be expected from the combination of systematic field studies of representative organizations, personal interviews, and analyses of basic statistical data regularly reported by all plans.

The subject matter to be investigated is vast and lends itself to innumerable special studies. For the purpose of appraising individual plans and groups of similar plans, information must be assembled that answers at least the following fourteen questions:

1. Is the plan operated for profit or incorporated as a non-profit organization?

2. Is the plan designed to pay cash indemnity or to render service in return for prepayments?

3. To what types of health conditions do the provisions apply?

4. What are the type, scope, amount, and duration of benefits or services?

5. What are the methods of organizing professional services, and what are the methods and rates of payment to the participating members of the professions?

6. What are the methods of organizing hospitalization and the methods and rates of payment to the participating hospitals?

7. What are the prepayment rates, extra charges for services, and additional obligations? Who bears the expenses and to what extent?

8. Where is administrative control vested, what is the composition of the administrative bodies, and what are their powers, duties, and functions?

9. What is the total number and the sex and age distribution of the persons enrolled at a given date?

10. What is the total number of participating professional persons, broken down by type of practice, and of beds in participating hospitals, broken down by type of service?

11. What is the number of eligible persons, by sex and age, who have received specified benefits or services during a certain period of time?

12. What is the number of specified benefits or services received by the eligible persons during a certain period of time?

13. What is the total earned income and the "other income" of the plan during a certain period of time?

14. What are the total expenditures for benefits or services and for administration, and what contingency reserves have been set aside during a certain period of time?

In evaluating the material assembled through the methods described before, including the systematic collection, proper classification, and correct computation of dependable statistical data, special attention must be given to the measurement of the services in regard to their quantitative and qualitative adequacy and of the costs in relation to both the average annual family income of the subscribers and the amount and quality of care received. The findings will show to what extent the plans encourage prevention of disease and promotion of good health, early diagnosis and treatment, and psychosomatic medicine; assure completeness, continuity, and consistency of service; improve the quality of medical care; and benefit the persons enrolled, the participating professional persons and hospitals, and the community as a whole.

Many unions and employers, of course, are not in a position to process or analyze such factual data even if they did make a continuing effort to collect the basic information. However, there is little doubt that their efforts in this regard would be rewarding. Several agencies, interested in medical care plan research, would welcome such information and would be willing to help the interested parties in its analysis and interpretation.

SUMMARY

Collective bargaining on health benefits is a new development in industrial relations. Voluntary insurance plans, however, have a long and varied history in this country. Employees in many occupations and industries have been covered under industry-sponsored programs. Certain unions also, from their earliest days, have provided health benefits for their members.

When employers and unions began writing health benefit programs into their collective agreements, they were carrying along a tradition already established for workers in industry. In some cases they organized special plans administered directly by one or both of the parties. In most cases, however, they participated in established commercial or non-profit voluntary health insurance plans.

This survey of voluntary plans has shown that they follow no single pattern. Classification is difficult, since they vary with respect to control, type of benefits, eligibility, scope of benefits, and standard of services. One fundamental distinction can be made between cash indemnity benefits and medical service benefits. In this respect, however, labor-management health programs frequently combine both kinds of benefits.

The establishment of these new management-union programs

through collective bargaining creates several problems which are quite independent of the operation of the health benefit plans themselves. Among questions raised by such problems are: what items to include in the contract; how to finance the plan; what basis to set for contributions; how to administer the "health fund"; how to arrange for handling day-to-day details; and what procedure to establish for settling disputes and grievances.

Evaluation of any health insurance plan requires the careful collection of several kinds of facts. Through this knowledge alone can sponsors of a plan determine the effectiveness of any plan and its cost in terms of the health benefits it provides.

Health insurance plans are designed primarily to ease the *economic* burden of illness. Finding a satisfactory solution to the economic problem is only one aspect of adequate health care for the country's population. As noted in this bulletin, certain health plans emphasize purposes other than economic. Medical care plans, however, make up only one type of the private and public health programs in the total picture. Among other important programs are those in health education, industrial hygiene and safety, professional medical education and research, public assistance to aged, dependent, and handicapped persons, public health, and workmen's compensation. Development of all health programs and cooperation among them will alone lead toward the goal — the raising of the health of the nation through prevention of illness and disease.

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