



BULLETIN

FEDERAL MEDIATION AND CONCILIATION SERVICE

SUBJECT: "Health Care Bargaining-The FMCS Experience"

No. : 76-BUL-128

Date: September 28, 1976

To: All Professional Staff

From: Jerome T. Barrett, Director
Office of Technical Services

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Attached is a reprint of an article co-authored by James F. Searce, National Director, and Lucretia Dewey Tanner, Labor Economist, OTS, entitled "Health Care Bargaining - The FMCS Experience" which appeared as the featured article in the July 1976 issue of the Labor Law Journal. The report attempts to summarize the Service's first year experience in this new role. I thought it might be useful in health care TA work. Additional copies are available from OTS.

In July we sent to each Assistant Regional Director copies of recent articles on the health care industry which would be helpful as background for working in the health care area. These included:

"One Year Under Taft Hartley" by Joseph Rosmann which appeared in the December 16, 1975, issue of Hospitals. The article examines the organizing activities in the health care industry during the first year.

"Anticipate Questions, Seek Answers for Adept Labor Relations Efforts" by Ronald L. Miller which appeared in the July 1, 1976 issue of Hospitals. The article discusses principles of unfair labor practices developed by the NLRB from a hospital viewpoint.

"NLRA Boards of Inquiry have been used Sparingly" by Norman Metzger. Also in the July 1, 1976, issue of Hospitals. In this article, FMCS statistics and case load are cited.

If you would like copies of any of these for your use in mediation, please contact the Assistant Regional Director or OTS.

Attachment

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Health Care Bargaining: The FMCS Experience

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ON AUGUST 25, 1974, amendments to the National Labor Relations Act extended coverage and protection to employees of nonprofit hospitals and other health care institutions. As stated in the amendments, the term health care institution applies to any "hospital, convalescent hospital, health maintenance organization, health clinic, nursing home, extended care facility, or other institution devoted to the care of sick, infirm, or aged persons." The new law covers an estimated three million workers and excludes employees of federal, state, and municipal health care facilities. State laws applying to private health care institutions were superseded by the federal amendments.

Several reasons were given for the passage of the law after a lapse of 39 years, during which time most workers enjoyed the protection of the Wagner Act. One reason cited was the attempt to lessen major disruptions in the medical industry which occurred over the right of employees to join a union, be recognized by the employer, and bargain collectively. A reading of the legislative history indicates it was Congress' intent that, by bringing nonprofit institutions under the act, strikes would be reduced and stability gained once the NLRB machinery became available.

Another reason for the passage of the amendment involved the question of equity and the continued discrimination of one category of employees. Work performed by employees in nonprofit hospitals is essentially the same as that covered by for-profit hospitals already under the Board's jurisdiction, it was reasoned.

Rather than merely extending the same provisions that exist for employees already covered by the NLRA, Congress enacted special features for the health care industry, including an increased notification period, a mandated mediation role for the Federal Mediation and Conciliation Service, a unique Board of Inquiry procedure, and



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Before joining the government, Ms. Tanner worked as an analyst with the Industrial Union Department AFL-CIO, had been a researcher with Service Employees International Union AFL-CIO, and an Assistant Director of the American Nurses Association's Economic Security Program. Ms. Tanner is on the Executive Board of the Washington chapter of the Industrial Relations Research Association and has written a number of articles on union activities and membership.

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a ten-day advance strike notice. These provisions were incorporated into the law to lessen the possibility of a strike and, in the event one is threatened, to provide sufficient time for the facility to prepare.

Special advance notices are required in the health industry. In contract renewal or reopener situations, the party desiring to terminate or modify an existing contract must notify the other party of such intent at least 90 days prior to the expiration date. Normal notification under the NLRA is 60 days. In health cases, the Federal Mediation and Conciliation Service and state mediation agencies must be given a written notice of at least 60 days of intent to terminate or modify the existing contract as contrasted to the usual 30-day requirement. In initial contract situations following certification or recognition, the labor organization is required to give at least 30 days written notice of the existence of a dispute to the FMCS.

Before any strike in the health care industry can occur, the labor organization is required to notify the institution and FMCS of its intention in

writing, specifying the exact date and time that the strike is to occur. The scheduled time can be extended by mutual agreement; however, if a strike does not occur within 72 hours of the specified time, another 10-day strike notice is required before any action can be taken.

After notification by the parties, FMCS is required to proffer mediation assistance and a mediator is immediately assigned to the collective bargaining situation. At the onset, the mediator attempts to determine whether mediation is required at the stage of negotiations, review the progress of bargaining, evaluate the likelihood of a strike, assess the possible impact a strike could have on the community and, finally, recommend whether a Board of Inquiry (BOI) should be appointed.

A Board of Inquiry is a unique feature of the amendment and is designed to provide factfinding in an attempt to avoid strikes. It is at the discretion of the National Director of the Federal Mediation and Conciliation Service that an impartial Board may be appointed to investigate the issues in-

involved in a dispute and to provide the parties and the Service with a written report of the findings of fact and a set of recommendations for settling the dispute.

As written into the amendments, a Board may be appointed if, in the opinion of the Director, "a threatened or actual strike or lockout affecting a health care institution will, if permitted to occur or continue, substantially interrupt the delivery of health care in the locality concerned."

This appointment is to take place no later than 30 days prior to the expiration date of the contract or within 30 days of receipt of the 60-day notice to the FMCS, whichever date is later. In the case of initial contracts, the BOI, if convened, must be appointed within 10 days of receipt of the 30-day notice to FMCS that a dispute exists.

FMCS Policy Decisions

During the course of administering the amendments, the Service has grappled with a number of issues raised by the amendments, primarily concerning the appointment of a Board. Until November 1974, decisions made to appoint a Board of Inquiry were based on a strict interpretation of the law, i.e., whether disruption of services would "substantially interrupt the delivery of health care in the locality concerned."

After reviewing the experience, a decision was made that the following factors would decide the appointment of a Board: (1) the potential impact of a strike or lockout on health services in the community and, if the impact is found to be substantial, (2) the possible impact of the introduction of the BOI on collective bargaining in the case. This second factor is viewed from the point of the status of nego-

tations, relationship between the parties, level of FMCS participation, types of issues involved, likelihood of a stoppage and the possible contribution of a Board of Inquiry.

Based on some months of administering the amendments, FMCS recognized that in some situations the appointment of a BOI may be reasonable given the possible impact of a strike criteria, yet negotiations may not have progressed to the point that a set of recommendations would be helpful. For use in such situations, the Service developed the use of a stipulation form. With this stipulation of agreement form, the parties allow FMCS to appoint a factfinder outside the time constraints of the amendment. In one situation, the parties would set a definite date by which time a factfinder could be appointed, while in other cases the expiration of the contract would be the final date for the appointment of a factfinder by the FMCS Director, if a decision is made to appoint one.

The Service has used this stipulation agreement in only a few situations. Even in these cases, there is no obligation to designate a Board or "Special Consultant," a term used in the person's appointment.

Situations occurred which pointed out that both mediation and appointments of BOI's were ineffective for resolving disputes when parties have cases pending before the National Labor Relations Board. In instances where an NLRB petition had been filed by either an employee or group seeking to have the bargaining agent rescinded, or where another labor organization is seeking representation, FMCS suspends the time requisites under Section 213 of the Act. In these cases, notices for health care institutions are suspended pending the resolution of the representation question by the NLRB. The suspension of time is limited to

the period within which FMCS must determine whether to appoint a Board of Inquiry.

Under the amendments, the Board is directed to investigate the issues and to make a written report to the parties within the 15 days after appointment. FMCS decided that the report and recommendations are to be given only to the parties with copies to the agency. Requests for Board reports are not fulfilled for a number of reasons, including the possibility that the parties might not have yet reached an agreement and the release would be untimely. It was also felt that any distribution of the reports should be made by the parties. In stating this policy, however, FMCS felt it reserved the right to issue a specific report in situations requiring special action.

At the onset, the agency recognized that a number of health care facility personnel and their employees would require information and training in collective bargaining and an introduction to the mediation process. Over

the months, the FMCS, in cooperation with the National Labor Relations Board, universities, and other groups, has held several conferences around the country devoted to the explanation of the health care amendments and the role of collective bargaining. In addition, the agency has sponsored training programs for health care groups, including the American Nurses Association.

As a further step, FMCS established a Health Care Industry Labor-Management Advisory Committee composed of 14 members, seven representing the major labor organizations in the industry and seven representing various segments of the industry. The Committee met in July 1975, and again in January 1976, to discuss the functions of FMCS, the criteria for Board appointments, qualifications of Boards selected, information required by mediators and the Boards on the health care industry, and an examination of the role of the reimbursement agency or third party payor in collective bargaining.

TABLE I

Type of Negotiations
Comparison of FMCS Health Care Cases to Total Dispute Cases

	Health Care ¹		Total Dispute ²	
	Total Dispute Cases	Percent of Total	Total Dispute Cases	Percent of Total
Initial Contracts	248	27.0	1,807	9.1
Contract Renewals	575	62.4	16,311	82.5
Contract Reopenings	97	10.5	1,422	7.2
Exceptional Grievances	7	.1	231	1.2
TOTAL	921	100.0	19,717	100.0

¹ Period of time covered extends from 8/74 to 8/75.

² Total dispute cases involved in fiscal 1975.

Note: Total dispute data appears in the FMCS Annual Report.

FMCS Caseload

During the first year of the amendments, between August 25, 1974, and September 1, 1975, FMCS received 921 reports from its mediators indicating that a case assignment has been closed. These reports represented 155,302 employees in the bargaining units and 617,679 workers in these health care institutions. Over one-quarter of the total closed cases involved first con-

tract situations, as compared to the nine percent figure for all cases FMCS handled during fiscal year 1975 (shown in Table 1).

Approximately one-third of all health care reports or 294 originated in the Western states, primarily California, and another one-quarter from the Northeastern region, specifically New York and Massachusetts. A distribution of health care cases by state within regions is presented in Table 2.¹

TABLE II

Number and Percent of Total and Health Care Closed FMCS Cases by Region and State, Fiscal 1975

	Total Cases		Health Care Cases	
	No. of Cases	Percent of Total	No. of Cases	Percent of Total
Region 1 Total	1,199	13.6	240	26.6
Connecticut	114	1.3	24	2.6
Maine	33	.4	1	.1
Massachusetts	291	3.3	61	6.6
New Hampshire	33	0.4	-	-
New Jersey*	207	2.3	18	2.0
New York	472	5.4	134	14.5
Puerto Rico	-	-	-	-
Rhode Island	31	0.3	2	.2
Vermont	18	0.2	-	-
Virgin Islands	-	-	-	-
Region 2 Total	1,090	12.4	99	10.7
Delaware	27	0.3	-	-
District of Columbia	80	0.9	3	.3
Maryland	101	1.1	19	2.1
New Jersey*	143	1.6	6	.7
Ohio*	10	.1	1	.1
Pennsylvania*	606	6.9	66	7.2
Virginia*	75	0.8	-	-
West Virginia	48	0.5	4	.4

* Geographical area of state divided between two FMCS regions.

¹ FMCS regions are shown in Table 2. In September 1975, Region 7 was divided into two. The new Region 8 includes Alaska, Oregon, Utah, Montana, Colorado, Washing-

ton, Idaho, Wyoming, and part of Nevada with Region 7 covering the remaining five states.

TABLE II—Continued

	Total Cases		Health Care Cases	
	No. of Cases	Percent of Total	No. of Cases	Percent of Total
<i>Region 3 Total</i>	707	8.0	16	1.7
Alabama	134	1.5	1	.1
Arkansas	2	—	—	—
Florida	99	1.1	3	.3
Georgia	85	1.0	3	.3
Kentucky*	15	0.2	—	—
Louisiana	74	0.8	1	.1
Mississippi	33	0.4	—	—
North Carolina	70	0.8	2	.2
South Carolina	14	0.2	—	—
Tennessee	172	2.0	4	.4
Virginia*	9	0.1	2	.2
<i>Region 4 Total</i>	1,189	13.5	143	15.5
Indiana*	9	0.1	—	—
Kentucky*	155	1.8	—	—
Michigan*	409	4.6	107	11.6
Ohio*	616	7.0	36	3.9
<i>Region 5 Total</i>	1,540	17.5	99	10.7
Illinois*	585	6.6	35	3.8
Indiana*	256	2.9	4	.4
Michigan*	20	0.2	2	.2
Minnesota	362	4.1	30	3.2
North Dakota	31	0.3	—	—
South Dakota	18	0.2	—	—
Wisconsin	268	3.0	28	3.0
<i>Region 6 Total</i>	1,438	16.4	30	3.2
Arkansas*	75	0.8	1	.1
Illinois*	87	1.0	3	.3
Iowa	238	2.7	7	.8
Kansas	126	1.4	1	.1
Missouri	428	4.9	18	2.0
Nebraska	61	0.7	—	—
Oklahoma	76	0.9	—	—
Texas*	347	3.9	—	—

* Geographical area of state divided between two FMCS regions.

TABLE II—Continued

	Total Cases		Health Care Cases	
	No. of Cases	Percent of Total	No. of Cases	Percent of Total
<i>Region 7 Total</i>	1,632	18.6	294	31.9
Alaska	28	0.3	1	.1
Arizona	40	0.4	3	.3
California	782	8.9	187	20.3
Colorado	93	1.1	2	.2
Hawaii	31	0.3	5	.5
Idaho	46	0.5	—	—
Montana	66	0.7	8	.9
Nevada	51	0.6	3	.3
New Mexico	33	0.4	1	.1
Oregon	142	1.6	23	2.5
Texas*	19	0.2	—	—
Utah	17	0.2	1	.1
Washington	272	3.1	60	6.5
Wyoming	12	0.1	—	—
TOTAL	8,795	100.0%	921	100.0%

* Geographical area of state divided between two FMCS regions.

A comparison of health cases with all FMCS fiscal year 1974 closed reports shows a wide degree of variation. In a number of states, for example, health cases represent a significantly higher percent of the total than all bargaining situations. In Michigan, 109 health cases, or 11.8 percent of the total, were completed, by contrast to the 4.8 percent of all FMCS cases. As a proportion of the total, health care bargaining takes place in New York at a higher rate than in all FMCS cases.

This same observation holds for Massachusetts, Connecticut, Maryland, Pennsylvania, Montana, Hawaii, Washington and Oregon. Thus, during this initial period, it appears that health care cases are not necessarily related in the same proportion as are all FMCS cases. Part of the reason may be the

higher degree of hospital organization in certain states, the one-year period studied, and the shorter duration of health care contracts.

As shown in Table 3, contracts negotiated in the health care industry are for a one- or two-year period; about 80 percent are under 30 months. This is in direct contrast to all contracts, of which about one-half are of a three-year duration or more. Approximately one-third of the health care contracts are negotiated for one year or less, compared to the 20 percent rate in all negotiations.

During the past year, FMCS recorded about 46 strikes in the industry. Calculated on the basis of all cases closed, this is a 4 percent strike rate. For all FMCS closed dispute cases, the strike rate is much higher: 15 percent in fis-

TABLE III
Length of Contract
Comparison of FMCS Health Care Cases to Total Dispute Cases

	Health Care ¹		Total Joint Meeting Cases ²	
	Total	Percent of Total	Total	Percent of Total
Less than 1 year	84	9.1	142	1.8
1 Year (1 - 18 months)	242	26.3	1,528	19.0
2 Years (19 - 30 months)	409	44.4	2,530	31.4
3 Years or more (31 - 42 months)	186	20.2	3,854	47.9
Total	921	100.0	8,054	100.0

¹ Covers the 8/74 through 8/75 period.

² Covers the 6/74 through 6/75 period.

Note: Joint dispute cases are defined as those in which a mediator holds one or more sessions with both labor and management representatives present.

cal year 1975. Prior to the passage of the legislation, strikes in the industry were primarily over the question of recognition. The two most important strike issues mentioned are wages and length of contract. Also cited as important issues were union security, vacations, holidays, hours of work, overtime, pensions, insurance, management prerogatives, and working conditions.

Two unions (Service Employees International Union, AFL-CIO, and District 1199, National Union of Hospital and Health Care Employees, a division of the Retail Wholesale and Department Store Union, AFL-CIO) and one professional association (the American Nurses Association, through its state affiliates) represent 65 percent of the

* As of January 1, 1976, 66 Boards of Inquiry and 17 Factfinding Boards had been appointed. A BOI is appointed within the time limits set by the amendments, conducts factfinding proceedings, and has 15 days in which to issue a report. The Factfinding Boards are distinguished from BOI pro-

921 closed bargaining situations and 122,000 or close to 80 percent of all employees in the bargaining units. Approximately thirty other unions and associations have been involved in bargaining in this industry, including such diverse groups as the Painters, Operating Engineers, and West Coast Longshoremens.

Hospital negotiations, as contrasted to nursing homes and other types of health care facilities, represent about one-half of the FMCS health care caseload; however, 70 percent of all workers are involved in hospital negotiations.

Boards of Inquiry

During the first four months since the effective date of the amendments, 24 boards were appointed.² Since Sep-

tember 1, 11 additional boards were named as shown below:

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Boards of Inquiry Appointed^a

1974	
September	1
October	18
November	1
December	4
1975	
January	6
February	1
March	1
April	3
May	4
June	9
July	6
August	1
September	3

In order to determine how the Board of Inquiry (BOI) procedure was working, the Service reviewed the BOI reports submitted to the Service and surveyed the Boards it had appointed and mediators who had been involved in Board cases.

Fifty-three (53) board reports were surveyed and 17 or one-third were found to contain no set recommendations. Of the seventeen, six included situations in which the parties either settled prior to the Board's issuing a report or before the Board had an opportunity to call the parties into a meeting. In the other 11 situations, the Board suggested that the parties continue bargaining.

A review of the Board reports shows that in a number of situations, particularly first contract situations, the

* Boards appointed have in almost all situations been arbitrators selected by FMCS from the agency's roster of neutrals. At the time the amendments were enacted, FMCS polled the professionals on the agency's roster

Board is faced with several unresolved issues, in a few as many as 20 or 30. In some cases, this reflects the fact that little bargaining has occurred prior to the Board's appointment. Frequently, it appears that the major provisions of a contract are left for the Board's determination.

Bargaining Issues

What are the issues that a Board deals with? One of the biggest issues raised by the hospitals and nursing homes is the question of ability to pay. Institutions frequently contend they may cease to operate, or can barely meet current expenses, or in critical situations have already filed Chapter 11 bankruptcy notice. This issue, in one form or another, has been raised in virtually all situations and the responses by the Boards have been varied.

Recommendations range from an extension of the contract for a short period of time to suggesting that its recommendations should not be contingent on the financial position as stated by the employer. One Board in New York City recommended that a joint committee be created to persuade third party payors to increase the present level of per diem rate of reimbursement to the same level paid in the other four boroughs of the city. Other Boards have, of course, taken an opposite view and dismissed the third party issue as irrelevant to the bargaining procedures. One BOI report stated "Section 213 of the NLRA does not provide for the third party payors to be present at nor are they properly party to the negotiation."

One of the major issues the Boards have been called upon to address is

of arbitrators to determine whether they would be willing to serve. Those responding positively to both questions were placed on a special list.

the issue of the union seeking to follow the pattern-setting hospital or nursing home contracts. As is frequently the case in initial contract situations, employees receive substantially less both in wages and benefits than those working in the pattern-setter institution. The Board is then asked to weigh the comparability and equity questions of the workers involved against the substantial burden that the giant leap in costs places on the employers. Each set of Board recommendations reflects the balance of such a judgment.

The Board relies heavily on the information presented by the parties, particularly practices in the health care industry. For instance, on the question of shift differentials, it has been the practice in the industry to pay a uniform amount for both what is considered the second and third shifts as contrasted with the prevailing practice in other industries to pay a higher rate to those working the third shift.

Weekend work is frequently brought up. In almost every instance, the union has a demand that employees be given at least every other weekend off and employers have objected that this limits their flexibility in scheduling. In general, the Boards reviewing this issue have suggested language which would provide employees with the time off, when possible.

Obviously, the most important issue considered by the Boards are wages and, in some cases, a cost of living increase demand. It is extremely difficult to categorize the wage demands, but generally meeting the pattern-setting contract is the wage gain sought. This is true also for fringe benefits, including special funds established for pensions and health and welfare.

Another frequently mentioned issue is the duration of the contract, most fre-

quently 2 years in the health care industry (compared to three years in other industries, as was pointed out). Again, the industry practice of a two-year contract is generally the recommendation.

The issue of proper patient care has generally been confined to units involving professional employees and is important in terms of negotiating priorities. Staffing patterns requirements and work schedules generally contained in the management rights clause are specific topics related to patient care.

In summary, the issues brought before the Boards are, in part, dependent on the type of unit involved. Units composed of professional employees are likely to raise proper patient care issues, the need for time off for additional training or attendance at professional meetings, while other units are more likely to be concerned with wages and working conditions. The length of the bargaining relationship is also an important factor. In initial or new bargaining situations, the relationship has not been institutionalized to the point in which both parties are secure. This stage in bargaining is frequently reflected in the large number of issues a Board is asked to review. The high number of unresolved contract terms also indicates the lack of bargaining 30 days prior to the contract expiration date.

Board Costs

Costs of Boards and factfinding proceedings are borne by FMCS. Information for 28 Board members appointed during 1975 shows that the average number of days worked by each Board is four, ranging from a 1-day session to a high of 20 days. In some cases, one person had been appointed to more than one situation, which accounts for the relative high of 15 or 20 days

assigned to one person. The average cost of each Board is approximately \$600.00, or about the same cost as the average arbitrator's fee.⁴

Of the 58 Boards appointed between the effective date of the amendments and the beginning of September 1975, 13, or less than one-quarter, have been in initial contract situations. Close to three-quarters of all Board appointments have been in the New York—New England region of the country. Several unions have been involved in Board proceedings, including District 1199, SEIU, the Operating Engineers, the Steelworkers, Committee of Interns and Residents, American Nurses affiliates, the Teamsters, Licensed Practical Nurses and the Laborers. However, over one-half involved District 1199.

Board of Inquiry Survey

To determine how the Board of Inquiry procedure was functioning, FMCS conducted an informal survey of the Boards of Inquiry appointed. The survey, in the form of a telephone poll, asked questions which could be divided into major categories: (1) what was FMCS' involvement in the BOI process; (2) how was the BOI functioning and how did it see its role; (3) were the legislated time periods realistic in the collective bargaining setting, and, (4) were there suggestions for improvements?

Twenty-six of the 46 persons who had served as Boards of Inquiry felt that the BOI procedures as provided by the amendments meet the needs of the parties.

Those who commented that the Board effectively met the needs of the parties expressed opinions that the appoint-

ment and time limitations provided a catalyst to bargaining and expedited the settlement process. Others who commented on the favorable effects of the Board noted that the Board served as a teacher for inexperienced bargainers.

Two basic criticisms of the procedure were cited. First, the 15-day time period specified in the law was termed too short in which to have the Board appointed, contact the parties, hold a factfinding session, and issue a set of recommendations. Second, it was recommended that Boards be appointed only in situations in which an impasse in bargaining has developed, generally not the case 30 days prior to the expiration date of an agreement. It was suggested by some Board members that the parties or the mediator assigned to the case be empowered to appoint a Board at any time prior to the expiration date.

Almost all of the Boards of Inquiry were in agreement that it is helpful for mediation to have taken place prior to the Board's appointment and that the mediator should be available to consult with the Board. The Boards also wanted to rely on the mediator to handle the necessary room arrangement and contacting of the parties for the factfinding.

A similar informal survey was conducted of those mediators involved in health care cases which eventually went to a factfinder. Almost all mediators polled had had more than one health care case, 12 had been involved in ten or more cases, and two had been assigned to one-half of all health care cases within a region. About one-half of the mediators noted that bargaining in this industry is different than in

⁴ According to the FMCS Office of Arbitration Services, the average total amount charged by an arbitrator in fiscal year 1975

was \$192.30 for close to three days and \$70.50 in expenses. The total average charge for an arbitration case was \$621.31.

others. These differences include the patient care and professional standards issue, the larger size of the bargaining committees in the health industry, the inexperience of the bargaining parties, and the reliance on attorneys for negotiating more than in other industries.

Mediators contacted varied in their opinions as to the effectiveness of mediation prior to a Board's appointment. In some instances, it was felt to be effective only when the parties had experienced several bargaining sessions. In only a few situations had the mediators not held conferences with the parties prior to the Board's appointment. For the most part, mediators hold no sessions during the period of the Board of Inquiry appointment; however, mediation was found effective during the post board period.

Most mediators stated they did not use different methods in health care cases, but did mention that they used active recommendations to both sides, since the pressure for a deadline is not as great in this industry. To many of the mediators, it did not appear that the parties were delaying bargaining in anticipation of a Board appointment.

The mediators, as the Boards, were divided on the issue of the rigid time requirements, with those opposed expressing the need for flexibility and those in agreement believing that such a timetable encouraged early bargaining.

Conclusion

After one year's experience under the amendments to the NLRA, the Federal Mediation and Conciliation Service has found that it is fully involved in the health care industry, both in terms of its caseload and policies. Health care cases represent over 10 percent of the agency's caseload; prior to the Act, there were few bargaining situations recorded. In a short period of time, the Service has adjusted its policy-making and administrative procedures to handle the specific requirements of the amendments and are constantly reviewing these in order to promote the Congressional intent.

During the year, the agency has surveyed the persons selected to serve as Boards of Inquiry, the mediators involved and reviewed the recommendations issued. No unanimous positions have been offered. Both Board members and mediators are divided on the effectiveness of the procedures and the rigid time frame established by law. The Board reports and recommendations vary greatly, ranging from no recommendations because of the lack of bargaining to a massive report setting forth recommendations covering virtually every aspect of the agreement.

One year's experience is too short a time in which to judge the effectiveness of the amendments. A final evaluation must await additional developments. [The End]

