TABLE 1—Summary of the Labour Force Classifications of the Canadian Population 14 Years of Age and Over

(Thousands of Persons)

	February 23	June 1	August 31
Total non-institutional civilian population	8,538,000	8,718,000	8,792,000
Civilian labour force	4,525,000	4,828,000	4,977,000
Employed	4,312,000	4,702,000	4,860,000
At work	4,207,000	4,581,000	4,656,000
With a job but not at work	105,000	121,000	204,000
Unemployed	213,000	126,000	117,000
Not in the labour force	4,013,000	3,890,000	3,815,000

(2). Includes all persons 14 and over in Canada except those living in institutions and those in the armed services.

By the end of August, unemployment was only about two per cent of the labour force. Moreover, it was estimated that 81,000 of the 117,000 unemployed had been looking for work for less than three months. On the basis of these figures, it does not appear that the pessimistic forecasts of mass unemployment after the war have been borne out.

The collection of labour force statistics in Canada is, of course, in its infancy. Experience will undoubtedly lead to more refined methods of collection and to modifications and improvements of definitions and classifications. Apart from the technical aspects of survey operations, much remains to be done in analyzing and explaining fluctuations in the labour force and its components. One question of major importance is the extent to which the war-time expansion of the labour force will be reversed in the next few years. Of equal importance is the extent to which the labour force fluctuates in response to seasonal and to cyclical influences. Of more vital concern are the fluctuations in the level of unemployment, its geographic and industrial distribution and its sensitivity to seasonal factors. Evidently, the intelligent application of a policy of full employment should be based on a careful study over a period of time of the Canadian labour force and its components.

Health — Labour's Concern

By Leo Price

PUBLIC attention was focussed upon labor unions' concern for the health of their members last spring. At that time John L. Lewis captured the newspaper headlines with his collective bargaining demands for coal miners. The United Mine Workers of America, his union, threatened to tie up all coal production unless a health and welfare fund was established by the mine owners. The first new comments expressed surprise and indignation over a demand for the control of an estimated seventy million dollar health fund rather than over the dramatic presentation of the gross neglect of the health of workers in a hazardous trade.

As negotiations proceeded, the press began to compare coal miners' demands with health and welfare programs financed

EDITOR'S NOTE: Leo Price, M.D., is the Medical Director of the Union Health Centre in New York, the unique organization created by the International Ladies' Garment Workers' Union to provide medical care for their members.

by employer contributions already in existence in other large unions. Frequent comparisons were made with the International Ladies' Garment Workers' Union because Lewis demanded *medical service* as well as funds for indemnifying workers in periods of sickness and disability. The International Ladies' Garment Workers' Union to-day is the only union which maintains health centres and gives and emphasizes medical service as well as sickness, hospitalization, and other cash benefits. Most collective bargaining agreements have been restricted to health insurance with indemnities, without providing medical services.

With these news reports a great proportion of the population heard for the first time about labor's concern with health. Historically speaking, however, interest in the welfare of the union members underlies the structure of many large labor unions.

An Old Tradition

All through history the costs of deaths, burials, sickness and doctor bills have fallen heavily upon wage earners. Co-operative devices of contributing to a general chest to pool resources and distribute the risk over groups of workers in similar limited circumstances have long been in operation. The ancient Greeks and Romans formed artisan societies which provided for the funerals of the members from sums contributed by all. Through the Middle Ages, English religious and craft guilds gathered funds to cover their members' expenses of sickness and death. When religious guilds were suppressed, Friendly Societies and fraternal organizations of workers arose to carry on the principle of association for protection against these unpredictable risks with which wage earners were unprepared to cope.

In the United States mutual benevolent societies paralleled the British friendly societies. The first was the Free African Society, formed by Negroes in Philadelphia in 1787. One of the best known, the Ancient Order of United Workmen, was organized in Meadville, Pennsylvania in 1868 to give fraternal assistance to members in sickness or destitution and to pay benefits to members for total physical disability. By 1900, mutual benefit associations numbered 2 million 5 hundred thousand members, collected premiums of over 4 billion dollars, and distributed benefits of 38 millions of dollars.[1]

As industrialization grew, many of the fraternal organizations and Mutual Benefit Associations formed among workers in the same occupation or factory developed into trade unions which carried on the tradition of concern for the welfare of members. The Philadelphia Typographical Society, for example, was organized in 1802 and incorporated in 1810 as a benevolent society. In 1833 it developed into the Philadelphia Typographical Union with the goal of obtaining adequate wages for journeymen printers. The Brotherhood of Locomotive Firemen and Engineers was formed in 1873 as a benevolent society and in 1885 was expanded into a trade union with the primary concern for wages, hours, and working conditions.

In most of the unions many difficulties were found in the administration of sickness benefit programs, often because from an actuarial point of view the financial basis of the insurance offered was unsound. Funds were managed unscientifically with little relation between the amount of assessments collected and the rate of benefits provided, or for long-term risks. There was a natural, but unconsidered, tendency to reduce assessments. Benefits were generally paid from the common fund in the union treasury which inevitably led to the question whether union and strike funds should be depleted to maintain benefit payments.

Sickness Insurance

On the whole individual union members who had experience with sickness benefit

1. "Development of Voluntary Health Insurance in the United States," by Donald K. Freedman, M.D., and Elinor B. Harvey, M.D.

programs enthusiastically approved of them. In 1935 a total of 74 unions in the United States[2] gave benefits of one sort or another to their members and a total of 26.11 million dollars were disbursed. Of this death claims amounted to 12.65 million dollars while only 28 unions gave sickness benefits in the amount of 1.05 million dollars. The remaining 12.41 million dollars distributed among union members covered unemployment, old age, and disability benefits.

Various Proceedings of the American Federation of Labor Conventions record that incomplete reports were received from affiliated unions regarding their sickness insurance programs. According to the A.F. of L., in 1913 the number of unions paying sickness benefits was 27; in 1923 the number dropped to 13; in 1933 there were 30 unions involved in sickness benefit payments; and in 1943 again there was a drop to 18 unions distributing cash sickness benefits.

The trend among unions in the last 30 years seems to have been away from this form of insurance. It is reasonable to suspect that the burden of collecting assessments for health programs, the problem of administering cash sickness benefits during difficult periods of unemployment, and the energy required in the organization and development of the unions in industrial disputes regarding wages and hours, should have influenced them against involving themselves in sickness insurance.

The trend away from union financed sickness insurance programs occurred in spite of the fact that premiums for sickness insurance were usually low. The National Federation of Post Office Clerks established a premium of 15c a week, while sickness insurance benefits were $10 a week for 16 weeks. The International Ladies, Garment Workers, Union,s usual premium was $4.20 a year; benefits for sickness were $7 a week for 10 weeks and also some prepaid medical service was given.

The unions as they were constituted at the turn of the century could not very well compete with the employers' welfare-work movement which then appeared in large industry. Whether this welfare movement was caused by an awakening of social conscience on the part of the employer, or whether it was an attempt to stem the tide of rising unionism, cannot be definitely determined. Regardless of the motives for employers' interest in the welfare of their employees, this movement coincided with and was helped by the development of industrial hygiene and medicine. The common object—healthy workers in a good environment—went hand-in-hand with high production, less absenteeism, and better employer-employee relationships.

The influence of the enactment of Workmen's Compensation laws at this period was an important factor in labor's interest in health. The principle was recognized that a worker's life and health is exposed to physical deterioration and destruction in industry just as there is wear and tear, breakage and depreciation in machinery and appliances. It is evident that trade unionists were impressed with the fact that the health insurance they secured either through legislation or as a gift from management was a responsibility of industry to which every industrial worker should be entitled. Many trade unionists felt that benevolent efforts on the part of employers to promote better morale, smaller labor turnover, and higher efficiency night serve to subsidize the worker so that he remains in a job when his best interests dictate leaving. They argued that when the union is designated as the administrative agency for group insurance, the worker has more opportunity for seeking his best interests in the industrial field without losing the security which insurance gives him against sickness and disability.

War-time conditions stimulated an impressive growth of group health insurance in industry between 1942 and the present

2. A.F.L. Report to the Executive Council of the 56th. Annual Convention, 1936.

time. When the wage stabilization program became a national policy, union leaders promptly added group insurance to the demands presented in contract negotiations with employers. In the arbitration of disputes, the National War Labor Board's policy to approve sickness benefit programs not exceeding 5% of the payroll influenced strongly the development of group health insurance as a feature of collective bargaining Since the payroll deduction could be counted as a legitimate expense of business, deductible from taxes, little employer opposition developed to the insurance demands because little direct expense was involved, due to high profits, heavily taxed, which existed during the war era.

Some of the larger, well-organized International unions formed and developed their own insurance companies, as in the case of the Amalgamated Clothing Workers' Union which established the Amalgamated Life Insurance Co., Inc., in Chicago. In some States, where this was not feasible, or where unions had limited organizations, they insured with commercial companies which offered sickness and disability insurance or other types of insurance suitable for a working group.

The Program of the I.L.G.W.U.

In New York the International Ladies' Garment Workers' Union handles the details of its health program through its local office, and its medical service through its medical department, the Union Health Centre. The Centre occupies 20,000 square feet in its own 27 storey skyscraper in the heart of the garment district in New York. General medical service, plus 19 specialty medical clinics and complete diagnostic departments crowd the floor-and-a-half of space in which medical work is done at present. The amount of medical service provided in 1945 may be seen from the following table:

Medical and Related Services Furnished by the Union Health Centre in 1945

Service	Number	Total
General Medical Clinics	40,749	
Specialty Clinics	52,562	
Sick Benefit Certification	24,652	
Laboratory Examinations	17,979	
X-ray Examinations	5,933	
Electrocardiograms	2,091	
Other Diagnostic Examinations	2,415	
Physio Therapy	14,846	
Injection Therapy	3,409	
		164,636
Drug Prescriptions Dispensed	48,129	
Optical Prescriptions Dispensed	8,118	
Chest X-ray Survey	4,702	

Expansion plans now underway envision the clinic in 5 floors with a total of 100,000 square feet of clinic facilities. One section of the lobby floor is completed. It contains a well-equipped, air-conditioned pharmacy, where International Ladies' Garment Workers' Union members obtain drugs at cost, an Information Service, and an allergy clinic. Materials and equipment are arriving and work has begun on the rest of the building program which should be completed within a year or so.

At the present time the clinic is staffed by 10 full time physicians, 65 physicians who give part time service on a session basis, and 35 physicians who do sick benefit certification at the homes of claimants or at hospitals where they may be confined.

Twenty-five nurses, 15 technicians, 4 pharmacists, and about 100 administrative, clerical and maintenance workers man the institution which functions 55 hours a week. These employees are organized in two separate unions—one for nurses and technicians, and one for clerical workers—both A.F. of L. affiliates. The work week for the staff is 39 hours, so that much administrative planning is required to keep the institution adequately staffed for the 55 hours it is open weekly.

The service is geared to the needs of garment union members, who for the most part obtain their medical care after the working day. This makes a con-

centration of service from 5 to 7 p.m. and on Saturdays, when pressure of work affects both the medical and the non-medical staff. As many as 1,000 services are rendered daily, with about 50% to 60% in the last two hours of the working day.

The establishment of the Union Health Centre in 1913 was an outgrowth of the general strike of the garment workers in New York City in 1910, in which the unsanitary conditions prevailing in the trade at that time was a major issue. The settlement of the strike was followed by the formation of the Joint Board of Sanitary Control, representing manufacturers and union leaders in the industry. The board was organized to correct the abuses of the old sweatshops. Shortly afterward a public health survey of the garment workers showed a very high incidence of tuberculosis and other serious diseases. The Union Health Centre was formed to offer the poorly paid garment worker an opportunity to receive medical care of a higher quality than was usually available to a person with low income, as well as to enable him to earn his living with the least possible interruption.

The institution began with an unpretentious and limited service, offering the patient service in those fields in which most attention was needed. Sickness insurance programs were undertaken, and the Centre examined all candidates for membership in the union and supervised the medical aspects of the sick benefit systems.

Financing the Program

In the early years medical services were furnished at a charge of $1. each —a fee still maintained for those few groups which still have no prepayment medical service. For the most part this nominal fee was paid by the individual patient, although some of the local unions provided two medical examinations per member per year. The cost of the medical service was much higher than the sums collected from patient visits and the deficit was met by the International Ladies' Garment Workers' Union.

The work of the Centre expanded steadily, as may be noted in the following table:

Medical and Related Services—1912-1945

Period	Services
1912-1915	11,909
1916-1920	36,630
1921-1925	95,290
1926-1930	86,864
1931-1935	145,580
1936-1940	418,281
1941-1945	632,674
TOTAL	1,427,228

and under the established system of financing the deficit to be paid became larger each year.

In 1942 the first International Ladies' Garment Workers' Union local obtained through collective bargaining a payroll tax upon the employers to finance the health and welfare program for union members. Ample funds thus secured were used to expand the sickness benefits which were already in effect through the premiums paid by union members. The usual rise was from the old rate of $7 a week for 10 weeks to $15 a week for 13 weeks. Other indemnity features were added to the sickness insurance programs: hospitalization benefits, surgical expense indemnities, maternity benefits. Prepaid medical service at the Union Health Centre was offered union members covered by the payroll tax levy, and other service features, such as home visiting nurse service and convalescent care, became a part of the health program.

Preventive medicine has long been a department of ILGWU health programs and this work has now been increased. Mass chest X-ray surveys have augmented the unique tuberculosis control program begun in 1913. Workers found to be afflicted with tuberculosis are required to leave the industry until the disease is arrested. They receive special indemnities, plus sanatorium care, and when they return to work they are

kept under close medical supervision. Eyesight surveys have been undertaken to the great advantage of garment workers who depend upon their eyes for their livelihood.

The immediate effect of the payroll tax levy upon the Union Health Centre was an unprecedented increase in the demand for medical service. By 1942 the facilities of the institution were already somewhat strained by the patient-demands for medical care, since the improved economic condition of the garment workers permitted the individual patient to utilize more fully the subsidized medical service available at the Centre.

After 1942 when more and more garment workers obtained prepaid medical care through their local unions, the rush of patients overwhelmed the physical capacity of the Centre. Expansion was impossible under war-time conditions, due to shortages of professional and clerical personnel, building materials, and medical supplies and equipment.

The goal of complete ambulatory medical service for the 165,000 garment workers in New York City has not yet been reached, but it is in sight. In the meantime every effort is being made to give as many union members as much ambulatory medical care as possible.

Evolution

Now that prepayment arrangements exist in over 70% of the groups affiliated, medical care is no longer restricted to the individual's ability to pay and the physician is no longer restrained from ordering costly and complex medical investigations, so that better medical service is possible. Between 1943 and 1945 a 224% increase was noted in the number of diagnostic services performed at the Centre.

While under prepayment care there may be occasional abuses due to unreasonableness on the part of the patient demanding service which he may not need or the indulgence of idle curiosity on the part of the physician who orders more diagnostic tests than strictly necessary, there can be no question that it results in better service to the individual patient and greater satisfaction to the attending physician.

Garment workers in New York are well able to get the best results from prepaid medical care. They appreciate its value, having benefited from over 30 years of health insurance through their own collective efforts. Through contract negotiations the International Ladies' Garment Workers' Union has extended health services for its members by the establishment of health centres in Fall River, Massachusetts and Philadelphia, Pennsylvania. Some medical service is provided for members in Boston, and other health centres are being planned in other cities of the United States. Sickness insurance is distributed in all sections of the country where the union has local organizations.

This progressive attitude in the provision of health service is fairly unique in labor history. It is not easy for a labor union to operate a health service program successfully. Much depends upon the union's internal structure, the geographical distribution of its membership, the sex, age, and other characteristics of the union members, as well as the hazards of the work in which they are employed. A thorough understanding of the complexities involved in the establishment of such a program, its objectives and responsibilities, can only be attained through knowledge of the rapid changes that are taking place in medicine for mass groups to-day and of the ideals to which a labor union should dedicate itself in giving its members limited or comprehensive service.

The topic of health and labor now concerns a large portion of the people. It also is of special concern to insurance companies, social and welfare agencies, the medical profession, and government. Wage earners in the past have been dissatisfied with the answers of society and the medical profession to the problem of good medical care. Charity clinics and hospital care did not satisfy them

—their self-respect demanded good medical service at a cost they could afford and at a time and place convenient to them. So far State and National governments have actually done very little to solve the worker's health needs as the worker sees them, although a movement for some social security has been initiated.

Therefore when war conditions provided the opportunity for labor to secure health insurance and service for the worker, the initiative was seized. Labor unions now have power to develop the kind of health programs they believe the workers prefer. No doubt past experience has generated policies within labor unions which will influence greatly their attitude toward management cooperation or government control of these health services.

Some Implications of Collective Bargaining

By H. D. Woods

EXPERIENCE in the field of industrial relations during the past few years suggests that important changes in the character of collective-bargaining institutions and in the objectives of labour through the collective bargaining machinery are taking place. The undue emphasis in the press on such manifestations of industrial unrest such as strikes, lockouts, illegal picketing and the like have obscured the larger issues and diverted public attention from fundamentals. Careful examination of the data reveal unmistakable trends which are of profound importance.

Observing the principle battlegrounds of industrial dispute helps one to understand more clearly what seem to be the principle issues, and particularly how the issues are being modified and reshaped under current industrial relationships. The impression one gets is apt to be confusing. Labor demands for wage increases, union security, the check-off, shorter hours, holidays with pay, and the like become involved with government policy regarding inflation, as reflected in price controls including wages and with the ambitions of political parties, both reformist and revolutionary. Labour demands and management refuses and does a lot of preaching. To add to the confusion, in this country, we face the problem involved in the reversion of the responsibility for labour matters from federal to provincial governments next April.

The problem is to see if all the bits and pieces of industrial relations can be fitted into a rational mosaic. To do this it is necessary to examine the purposes of collective bargaining and the forces governing the process.

The two sides to the wage contract are the employer and the employee. The employer often believes he has little or no need to deal collectively with his employees. Traditionally he has opposed the organization of the workers and has used every possible device to prevent organization. The law, bargaining power, the yellow dog contract, the lockout, the company union and other instruments including violence have been used to prevent independent organization. He has likewise attempted to limit the activities of unions after they are organized. In other words these workers' associations have had to establish the right to exist on the one hand, and the right to act on the other.

Employers have been surprised at the toughness and persistence of trade unionism. This arises out of the nature of the wage contract. The employer bargains either directly, or through an employers' association, whichever he thinks is the stronger. The worker has been turning

EDITOR'S NOTE: H. D. Woods is Associate Professor of Industrial Relations at McGill University.