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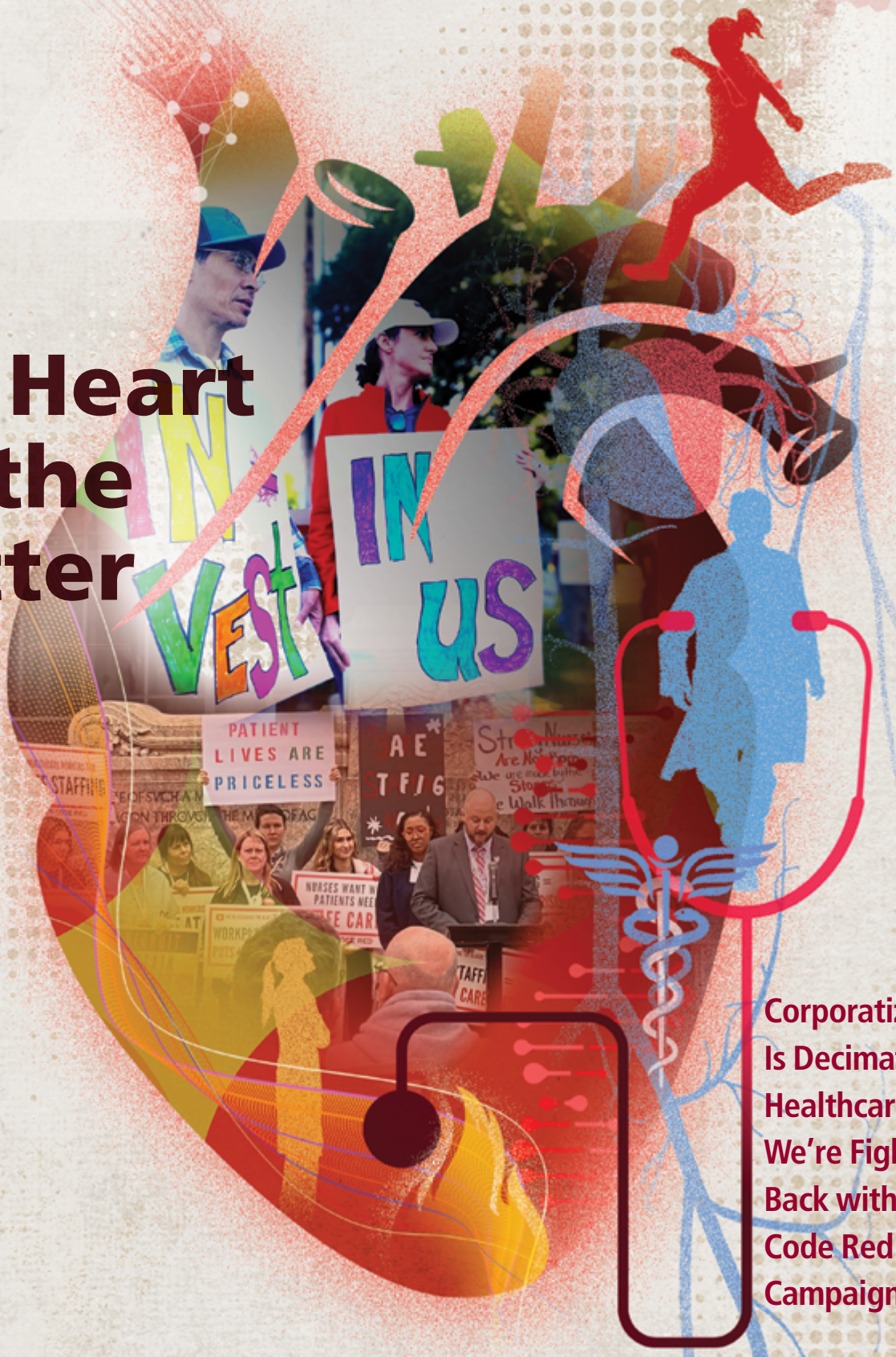
A BIANNUAL JOURNAL ON HEALTH AND COMMUNITY WELL-BEING



The Heart of the Matter

Corporatization Is Decimating Healthcare, But We're Fighting Back with Our Code Red Campaigns

Voting to Put Patients Over Profits

RANDI WEINGARTEN, AFT PRESIDENT

YOU WOULDN'T GUESS it from the constant roar of bad news, but things are looking up. Yes, more needs to be done—and Kamala Harris is charting a path to lower costs and help more and more folks move into an enduring middle class—but wages are up, inflation has cooled, and the Biden-Harris administration has created more jobs than any other in history. America's economy is the strongest in the world. Biden and Harris have invested in our country's future—in our roads, bridges, electrical grid, manufacturing sector, hospitals, and schools. They cut child poverty in half.

And the labor movement is in a renaissance. Labor activism is sweeping the nation, and our union has never been stronger. The AFT now has 1.8 million members and is the nation's fastest-growing healthcare union.

Kamala Harris and Tim Walz are fighting for us. Their North Star is making life better for working people.

Harris and Walz have pledged to invest in great public schools and make college affordable for all. They want to expand the right to organize and have proposed policies that increase wages, make housing and healthcare more affordable, and fight price gouging to lower grocery, gas, and prescription drug prices. They will strengthen Social Security and empower working people to organize. They've vowed to protect our fundamental freedoms, from voting to making reproductive decisions. They champion an opportunity economy that ensures everyone can not only get *by* but get *ahead*.

In contrast, Donald Trump is more dystopian and angrier than ever. His policies are embodied in Project 2025—an authoritarian, anti-American, deeply unpopular agenda written by Trump acolytes. (The goal, according to its chief architect, is "institutionalizing Trumpism.")

Take healthcare. Project 2025 eliminates protections for people with preexisting conditions. It allows the government to monitor pregnancies, prosecute people if they miscarry, and imprison doctors and nurses who treat patients experiencing pregnancy-related health crises. It bans Medicare from negotiating drug prices and cuts Medicaid.

What would Harris and Walz do? Build on the progress made by the Biden-Harris administration. As you'll read in this issue (see page 38), Medicare can now negotiate lower prescription drug prices, and the cost of insulin is capped at $35 per month. Medicaid and the Affordable Care Act (ACA) have been strengthened, increasing the number of insured people to the highest in history. This administration has secured billions to: Train more nurses. Invest in community health workers. Prevent and treat cancer. Improve geriatric care, including home care. Keep rural hospitals open. Expand mental health care. Biden and Harris also have taken on the corporate "medical-industrial complex," from protecting patients from surprise medical bills to proposing federal standards for hospital maternal care.

High-quality healthcare is a right. And Harris and Walz are taking steps in that direction: Expand the ACA and extend Medicare's $35 cap on insulin and $2,000 cap on medications to *all* Americans. Make permanent the Biden-Harris tax credits that are lowering healthcare premiums for millions of Americans. Work with states to cancel crushing medical debt. Combat maternal mortality.

That is their plan. What is Trump's? He told us in the September debate that he has "concepts." Instead of concepts, let's look at the reality on the ground and what a Trump victory would mean.

The three articles that open this issue, featuring nurses in Connecticut, Oregon, and Montana, show that short staffing is causing a surge in workplace violence and driving workers out of healthcare. Through our Code Red campaigns, we're fighting back with legislation and collective bargaining. But as the next three articles on financialization in healthcare show, to win the care that our patients deserve, we must defeat corporate greed. *That will be much harder under Donald Trump. Project 2025 demonstrates that he stands with the ultra-rich.*

As private equity is buying up hospitals, cutting staff, and selling off assets, the Steward bankruptcy (see page 18) is Exhibit A for how greed decimates healthcare. The AFT represents nurses at Steward's Hillside Rehabilitation Hospital in Warren, Ohio, which faces an uncertain future. Despite this, our nurses show up for work every day and care for their patients. That's why I showed up to the Senate hearing on Steward in September, even though Steward's then-CEO Ralph de la Torre didn't. *Project 2025 will reward people like de la Torre with tax cuts, while making it harder to vote for leaders who actually care about workers.*

We are at a historic juncture. In November, let's get out the vote for a country where healthcare is a right, hospitals put patients over profits, and healthcare workers are treated like the heroes you are. ✚

Harris and Walz's North Star is making life better for working people.

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The Heart of the Matter

aft Education Healthcare Public Services

Our Mission

The AFT is a union of professionals that champions fairness; democracy; economic opportunity; and high-quality public education, healthcare and public services for our students, their families and our communities. We are committed to advancing these principles through community engagement, organizing, collective bargaining and political activism, and especially through the work our members do.

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COURTESY OF CONNECTICUT SENATE DEMOCRATS AND BACKUS FEDERATION OF NURSES

A Path Forward

Championing Healthcare Worker Safety in Connecticut

The murder of home care nurse Joyce Grayson in October 2023 put a spotlight on the crisis of workplace violence for health professionals in Connecticut—a growing problem that union activists have been sounding the alarm about for decades. In the wake of this tragedy, healthcare workers and legislators came together to pass landmark workplace violence protections. To learn more about the problem of workplace violence and what this new law means for healthcare professionals in Connecticut, we spoke with Sherri Dayton, AFT Connecticut divisional vice president for healthcare and president of the Backus Federation of Nurses, AFT Local 5149, and Martha Marx, former president of the Visiting Nurse Association of Southeastern Connecticut, AFT Local 5119, and state senator for Connecticut's 20th district.

–EDITORS

EDITORS: What brought you into nursing, and how have your work and your activism shifted over the years?

SHERRI DAYTON: I was in and out of the hospital for the first couple of years of my life, and I had such kind healthcare professionals and nurses taking care of me. When my preschool teacher asked me what I wanted to be when I grew up, I immediately knew the answer: I wanted to be a nurse.

I started as a certified nursing assistant; after working as a home health aide, I became a patient care technician. In 2006, I got my associate degree as a nurse. Eventually I got my BSN online, and last year I finished a master's degree so I can work as an advanced practice registered nurse. I practice at a primary care facility now, but I've stayed on with the Backus Federation of Nurses as a retiree so I can continue as president and train the next generation.

Over my career, I've seen terrible changes in healthcare, mostly related to the increasing pressure healthcare corporations put on health professionals to care for more patients with fewer resources. We're chronically understaffed, and we have more patients as baby boomers age but fewer places to put them because healthcare organizations continue to close "unprofitable" departments and facilities. We're already seeing people on their worst days, and longer wait times and stressful conditions for both patients and healthcare professionals push tensions higher and higher—and eventually people crack. That's how we got to where we are today, with jaw-dropping rates of workplace violence for healthcare workers.[1]

MARTHA MARX: I've been a nurse for almost 40 years. My mother died when I was a senior in high school, after a long sickness. I did a lot of her caregiving, and it made me feel good to be able to help. That's why I went into nursing, and if I had to do it all over again, I would make the same choice. I just love what I do.

After I got my BSN, I started in pediatric oncology, and then hospice care. I transitioned to contract-based home healthcare in 1998 because my kids were school age and I wanted as much flexibility as possible. I joined the union, the Visiting Nurse Association of Southeastern Connecticut, as soon as I could. A few

months later, when there was an opening, I agreed to run for president.

I loved being union president, but working in home care is what eventually pushed me into politics. I saw how health policies weren't working for patients or workers, and I wanted to fix it. For example, the state wants to keep elderly people out of nursing homes because it's cheaper, but we're doing it on the backs of homemakers and companions—mostly women of color—who are providing in-home nonmedical care for next to nothing.

I first ran for City Council in 2015, and I won. Since then, I've lost a lot of elections—including council reelection and state Senate twice—but I didn't let those losses stop me. In 2021, I won my council seat back, and in 2022, I won my Senate seat.

EDITORS: Workplace violence is on the rise. What have you seen and experienced?

MARTHA: I've been talking about workplace violence for 20 years as a home care nurse and as a union president. The norms of care are so different for us—we're working with patients in their homes, and we don't have any control over our environment. We've requested escorts when we didn't feel safe, but mostly we haven't been taken seriously.

"In all my years, I've never seen so many nurses ... leave not just a job but the profession."

–SHERRI DAYTON

COURTESY OF BACKUS FEDERATION OF NURSES

The dangers we face became headline news in October 2023, when nurse Joyce Grayson was murdered while doing a medication admin visit.[2] That tragedy brought a lot of attention to the crisis and promises of better protection, but little actually changed at work in the aftermath.

In December 2023, I was sent to visit a man who was recovering from surgery. I knew he had a history of opioid use disorder and had been on methadone, and I saw a crack pipe underneath his nightstand. That doesn't automatically mean he's dangerous—but changing his bandage was taking a long time, and I could tell that he was escalating, so I finished as quickly as I could. At the office, when I opened his medical record to get his prescriptions refilled, I saw that not even a month before his recent surgery, he'd had to be medically restrained in the emergency department (ED) because he had bitten the security guard and threatened to come back and shoot everyone. And there I had been, alone with him in his house, sitting on his bed.

Management was supposed to be doing safety assessments. Why didn't they check his history? They apologized profusely, and since then they've sent two people together to that patient. But a few months later, they sent me to another patient who should have been flagged but wasn't. When I asked about it, management blamed their faulty internet. I don't see a lot of patients when the Senate is in session, but that's two times in five months that management has made it clear that my safety isn't their priority.

My colleagues all have similar or worse stories. One home health aide, a Dominican woman, had an angry patient tell her that he was going to put her in a barrel and ship her down a river back to the country she came from. When she reported it, management said, "We called him and he says he really likes you, so you should keep seeing him."

SHERRI: We all have these stories. I've been hit, kicked, spit at, threatened, pushed, had bodily fluids thrown at me. I've had my life threatened. I've been sexually harassed and touched inappropriately.

As a coworker, and as a union president, I've also witnessed many horrific things. I've seen patients come in with guns, knives, or drug paraphernalia that can cause injuries, like needles or glass pipes. I've seen security guards get their hair pulled out and nurses get punched in the face. I've had members get concussions that cause horrible migraines for months, and others who got flipped by patients and had to have shoulder surgery. The physical injuries eventually heal. But worse is people who acquire posttraumatic stress disorder (PTSD) after being assaulted and are never able to return to a profession they loved. Prior to COVID-19, almost 21 percent of nurses met the diagnostic criteria for PTSD.[3] I'm sure that number is higher now.

Violence drives people out of the profession in multiple ways, and we already have high turnover rates. In all my years, I've never seen so many nurses fresh out of nursing school leave not just a job but the profession in the first five years. They put in all the hard work to earn an RN but walk away because it's not worth it. They get less stressful jobs waiting tables or in retail. I know one nurse who became a truck driver.

EDITORS: How have you tried to address the issue over the years?

SHERRI: The existing workplace violence law in Connecticut requires each hospital to have a committee that meets regularly. In my hospital, it's a subcommittee of the safety committee. We were doing sweeps where we'd visit different floors and talk to the staff. We also reviewed instances of violence to find trends and do root-cause analysis. That all stopped when COVID-19 hit, and we've never gotten back to the same place. It took nine months to resume meetings, and it took another nine months to have the incidents reported out again. Then the hospital tried to revert those meetings to general safety committee meetings, where they deal with patient falls and needle sticks, but we successfully fought that too.

We have made progress in other areas. We have a gunpowder-sniffing dog that rounds occasionally. And the ED has a place to unload guns safely and a locked safe on the premises, as well as shields to protect nurses from being spit on. We're in negotiations and

trying to get contract language on metal detectors, like some other AFT Connecticut locals have, but so far the hospital claims they are too expensive.

As far as federal legislation, US Rep. Joe Courtney has been trying to pass a bill that would require the Occupational Safety and Health Administration (OSHA) to develop a workplace violence standard,[4] and we'll keep fighting for that. One of the biggest barriers to our efforts is that we aren't collecting enough information. Hospitals have only been required to report the OSHA 300 logs (i.e., if someone is hurt enough to miss work or require medical care beyond first aid). But I can't tell you how many times nurses are hit, punched, bitten, or threatened—and none of that has to be reported. We're missing a huge piece of the picture.

MARTHA: We get a lot of pressure to not complain. We know we have to protect ourselves and each other because management won't do it. When we have a home visit in a situation that feels unsafe, we ask a friend to call in 10 minutes and dial 911 if we don't answer. We know if we tell management, they'll just give that case to another nurse without telling them the first nurse felt uncomfortable. Or they'll assign it to a male nurse. But why should he be put in an unsafe situation? When younger nurses get hit on by patients who start stalking them on Facebook, management tells them to set better boundaries or passes the patient on to another nurse. So after we complain, we're both angry at management and afraid for that other nurse—it feels like we've set them up to be assaulted. And management is gaslighting us, making us feel like if we can't deal with it, we're not good home care nurses. We're stuck: we want to provide all our patients with care and also care for each other.

Compounding the problem, one "fix" collapsed. Before my agency was part of Yale New Haven Health, we had a meeting with the police department, which then assigned us retired police officers as escorts. That made us feel a lot safer—but then one of the officers was arrested for dealing drugs. That tanked the escort system, and we haven't had one since.

EDITORS: You won significant workplace violence legislation this year. How did you organize for this victory, and how will this legislation help keep healthcare workers safe?

MARTHA: After Joyce was murdered, I called the Senate chair of the public health committee and the president of the Democratic caucus and told them we needed to hold a press conference. This tragedy exposed how little protection home care workers get. You don't want to go into someone's home fearful or making assumptions—but nurses' concerns about safety must be respected. That press conference brought much-needed scrutiny to the lack of safety practices.

The Senate Democrats made the health and safety omnibus bill, SB 1,[5] the top priority, and the bill—now law—starts with the safety of home care workers. That includes nurses like me, as well as in-home companions and homemakers. I don't know whether that would have happened without a home care nurse in the Senate—and as vice chair of the public health committee—to speak knowledgeably to these issues and champion this cause. Senator Saud Anwar (the public health committee chair) consulted me throughout, and I read the bill often to make sure that the home care and hospital associations weren't watering it down.

SCREENGRAB / CT-N VIA CT NEWS JUNKIE

One major provision I worked on requires intake nurses to collect more thorough information about patients and conduct a safety assessment. They have to check judicial and sex offender records and verify whether a patient has any history of violence toward healthcare workers, substance abuse, or domestic violence. They also have to get a list of the patient's diagnoses and determine whether those diagnoses (e.g., diabetes or a psychiatric diagnosis) have remained stable, what services will be provided, where in the home we can provide private care, and whether there are weapons or other safety concerns in the home. No services will be denied because of the answers to these questions, but any worker assigned to those clients can access the information and decide whether they want to request an escort.

The law also requires that home care agencies perform monthly safety assessments with the workers who are providing direct care and develop and implement home care health and safety training curriculum in order to receive Medicaid reimbursements. The agencies must report verbal threats and abuse to the state public health department as well as physical or sexual abuse, and they must take steps to protect home care workers in response. That reporting is only required annually, which isn't enough, but any mandated reporting at all is a huge change for us.

Finally, the law establishes a working group to continue studying and developing additional solutions to the safety issues home care workers face. The group must include at least three representatives from home care agencies, including a direct care worker, and representatives from relevant unions and nurse associations.

SHERRI: We paid attention to the promises legislators made at vigils for Joyce in October, and we held

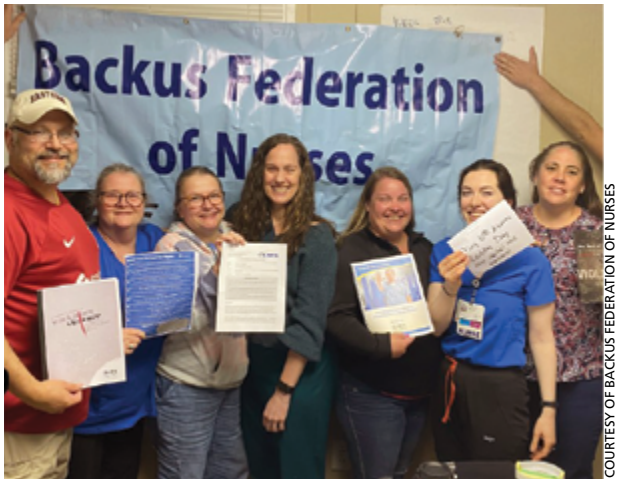
"You have to go to your state legislators and tell them what's happening in your workplace."

–MARTHA MARX

them to those promises. We did a lot of organizing, lobbying, letter writing, and calling, and we held meetings at the state house. Because of the horrific situation, there wasn't much pushback. Even with healthcare organizations, home healthcare companies, and the hospital association, we got much less resistance than usual. They knew we had the public on our side.

The provision relevant to hospitals is short but powerful because it requires healthcare organizations to comply with Joint Commission (JCO) standards for workplace violence[6] or be subject to state audit. JCO establishes a definition for workplace violence that includes threats, intimidation, and bullying along with physical injuries. That's a huge shift in how we can push hospitals to think about—and act on—incidents of workplace violence.

The first JCO standard says hospitals must conduct an annual analysis of their workplace violence prevention program and act on the results. In my hospital, that means we now have a legal means to make management resume our pre-COVID-19 practice. The standards also broaden what hospitals must monitor, report, and investigate to include injuries that occur in the hospital, occupational illnesses, property damage, safety and security incidents, and more. Healthcare workers are often discouraged from calling the police or pressing charges because we're told there's no point. But the JCO standards support that these incidents need to be reported. At the very least, those data will help us pass additional legislation. In addition, the standards require hospitals to provide regular training, education, and resources to staff. Right now, only ED and psychiatric staff get training, but workplace violence happens in every department.



COURTESY OF BACKUS FEDERATION OF NURSES

The bill doesn't fix the whole problem, but it gives us a path forward. It's terrible that the catalyst was someone dying. Joyce's son is a critical care nurse at Backus Hospital, and we're determined to keep this from happening again.

EDITORS: What advice can you offer other AFT affiliates fighting for similar legislation in their own states?

MARTHA: It's essential to understand the process of how a bill becomes a law and how to advocate effectively. You have to go to your state legislators and tell them what's happening in your workplace. It's also important to know how your state government works so you know where to focus your energies. We went through the public health committee, but in another state the labor committee might make more sense. You also need to find the politicians who will be your champions—and then make sure you support them when they need it because running for office isn't easy.

Also, know before you start that you might need to take baby steps. You have to run a slow, steady race with anything in government. Take our sick leave fight, for instance. The hardworking people who provide in-home nonmedical care were carved out of Connecticut's 2011 sick leave law because of their federal job classification as "maids." I'm so proud that we passed a bill this year expanding paid sick leave so now everyone is covered. That only happened because advocates were persistent. Your legislators talk to lots of people every day, so you need to remind them often that you're paying attention. Believe me, the persistent advocates are the people who get what they want.

SHERRI: Be prepared for a lot of work. One of the basic things that we've done is get pro-union people—like Martha—into the state Senate and General Assembly. I'd like to say there was an easier way, but it's grassroots. You have to get people who share your values to actually run—and then you have to turn out the vote for them.

It's also important that people tell their stories. I can go to the state house as a union leader and talk to someone, and they can write it off as the union just making noise. But if Joyce's son talks to the press about his mother being murdered, it's a whole different conversation. I know it's hard to tell those stories and relive those terrible experiences. But it's so important to tell them if you can, so the next person doesn't have a story to tell. The more people speak up, the more legislators have to acknowledge how widespread the problem is.

And, as much as we appreciate this victory, we know it's just one step—not a solution. We need to ensure strong implementation, including workplace violence committees, evidence-based training, and collecting real-time data.

Our union hopes to have a training program in place at Backus in no more than a year. We're also putting workplace violence language into our bargaining proposals, and we're willing to stand on the line if we need to in order to get that language into our contract. We have a lot of work ahead of us, from the local level to the state level. We know this is a great victory, and we're going to celebrate it, but then we'll be right back at it. ✚

For the endnotes, see aft.org/hc/fall2024/dayton_marx.

From Complacency to Victory

Increasing Staffing and Safety in a Portland Hospital

PHOTOS COURTESY OF OREGON NURSES ASSOCIATION

I became a nurse in 2006. It was rock climbing and mountaineering that drew me to the profession. One day my climbing partner split his head open, and I had to take him to the emergency department (ED) to get stitched up. And then I had this epiphany: "Look at all these people living in Jackson Hole with great jobs who work as little or as much as they want." I went straight to nursing school, and an internship in emergency nursing showed me that's where I belong. I love being there in a person's scariest moment and reversing their trajectory toward death.

I came to Portland's Oregon Health & Science University Hospital (OHSU) in 2010, and I've been in OHSU's ED ever since. I've always appreciated the Oregon Nurses Association (ONA), but COVID-19 drove me to become very active in the union. ONA was the only entity that cared about frontline workers. While administrators gaslighted us, the union acquired P100 masks from all the welding shops in the Portland metro area to keep us protected.

But the pandemic isn't the main reason I'm active in the union now. It's my 18 years of stories: everything from being assaulted to coming to the rescue of my peers. My first assault happened before I came to OHSU. I was a very young and very pregnant nurse taking care of a teen needing psychiatric care. As we were trying to restrain him to a stretcher, he kicked me in my belly. It was one of the most terrifying experiences I've ever had. (Fortunately, my baby was fine.) I learned very early that we can't have real safety without safe staffing.

A couple of years ago, when volunteers were needed for the contract bargaining team, I stepped up for the first time. Bargaining lasted 10 months—from the end of 2022 to September 2023—and it was one of the hardest things I have ever done in a professional capacity. But I enjoyed it because I learned a lot, and

By **Diana Bijon**

Diana Bijon, RN, has been an emergency department nurse for 18 years and is a member of the Oregon Nurses Association and the Association of University Registered Nurses contract bargaining team at Oregon's largest hospital, Oregon Health & Science University.

we won significant raises and important staffing and safety provisions. Before I share details of what we won, I want to paint a clearer picture of the challenges we faced.

Guns, Assaults—and Short Staffing

When I started at OHSU, it was awful. There was the thinnest staffing that I'd ever experienced, and there were no safety protocols for patients whatsoever. No screening procedure, no metal detector. All entrances to the hospital were open to anyone, anytime. Patients came in with guns. They didn't necessarily have ill intent; motorcycle and car crashes brought people in with guns strapped to their waistbands or in their purses.

I learned very early in my career that we can't have real safety without safe staffing.

The ED entrance now has a metal detector, but there are other ways to enter the hospital. Not long ago, a patient came into the ED waiting room through a back stairway and entrance that were unguarded and unlocked. He got all the way into the triage treatment area where there were five other patients and announced, "I'm suicidal, and I plan on shooting myself. Here's my gun." Our nurse had to immediately intervene to take the weapon. The metal detector has helped a lot—security has confiscated many guns and knives. But unexpected things get through. One patient brought big bottles of accelerant and lit a waiting room bathroom on fire.

To those who haven't worked in a crowded ED, such things might be unimaginable. To me, they are the expected consequence of failed infrastructure—meaning not having adequate resources, including people and their different specialties, physical space, and supplies to meet the demands of this job.

At OHSU, we have a 31-bed ED for a 650-bed hospital, which is about half the size the ED should be. The hospital is always beyond its capacity, so we also have an ED boarding crisis in which hospitalized patients stay in the ED in hallways or the waiting room—some even beg to sleep in their cars. The consequences are often severe, particularly given the hospital's prior practice of staffing just one triage nurse for 10 hours of a 24-hour period. For example, I was the lone triage nurse for one shift, and I needed to go to the waiting room to get a patient who had come in with stroke symptoms. Because there's no way to see into the waiting room from behind the door, I inadvertently stepped right between two men—both also patients—who were fighting. One had crutches, which he had raised like a weapon. Using my loudest "mom" voice to stop the fight, I took the crutches. Then, I was able to leave and go push my panic button, which was back inside the locked waiting room door, around a corner, and under a counter. I should never have been alone in that situation. That fight would not have happened if there had been an additional triage nurse tending to the waiting room.

Unfortunately, that story is not unique. During yet another shift in which the ED did not have enough staff, one nurse was assigned to four separate trauma bays, where we treat our most critically ill patients. I was the charge nurse that day and I was in triage, far from the main ED, covering a break for the only triage nurse. A patient arrived as a trauma activation after a car crash. He was stable and seemed fine. But when he returned to the trauma bay after a CT scan, he got out of bed, rummaged through the room, and found a scalpel. My nurse walked in to check on him and found him waving the scalpel around, screaming. Alone with no code button, the nurse stood in the doorway, found one of our portable phones, and called me. This nurse is a close friend, so I immediately heard the urgency in his voice. I dropped everything and ran. By the time I got there, the patient was sitting in a corner stabbing his own eye with the scalpel. Our public safety officer arrived and stopped the patient by tasing him.

I'll share one more incident—one that only avoided tragedy because the nurse involved was young and fit. He was covering a break for our psychiatric assignment, and we were terribly overcrowded: there were three filled patient rooms in front of him, a fourth patient on a stretcher behind him, and a fifth patient on a stretcher just outside one of the rooms. A patient exited one of the rooms and attacked the nurse, dragged him to the floor, and hit him. Two consulting physicians (from an outside practice) passed through and just stepped over this struggle—it's on the hospital's security video—because they were so desensitized to hospital violence.

Thank goodness, our nurse was able to get control of the patient. By the time public safety arrived, the patient was back in the room with the door locked. The crisis was over, but the trauma remained—for the nurse and for the other patients.

The Power of Collective Bargaining

Despite these and many more traumatic incidents, our union had to fight through hundreds of hours of negotiations. Ultimately, we won our strongest contract ever, with wage increases of 15 percent in the first year and 6 percent each of the following two years, plus several new staffing and safety provisions.* By the end of bargaining, the administration understood how unsafe our workplace really is. Tragically, one reason they grasped what we were saying is that while we were bargaining, an unarmed security officer was shot and killed, and two additional staff injured, at another Oregon hospital.

One huge step forward in our contract is an ED staffing grid that lays out how many nurses we must have in every four-hour block of a 24-hour period. When I started at OHSU in 2010, the ED was run with 12 nurses. With this new contract, we range from 24 to 30, allowing a nurse for each trauma bay. In addition, a 1:3 ratio is written in for acute care, along with a guarantee to follow professional standards in other areas and enhancements to staffing plan enforcement.

We also argued for a dedicated, 24/7 public safety presence in the ED instead of shared presence with the rest of the campus because the ED is the epicenter of so much hospital violence. Our administration fought that tooth and nail. They wanted to continue with coverage "as best as possible." But we didn't back down, so now we have 24/7 security presence and metal detector screenings in the ED.

Since my first assault on the job, I've taken self-defense training, including courses taught by female police officers and courses on how to safely handle a gun. I did this to try to stay safe at work—but I had never had such training offered through work until now. We added de-escalation training, including physical training, to this contract for the first time. It is necessary. If you're going to be a part of a team of nurses and public safety staff who have to physically control a patient, you need to be very practiced and coordinated to keep that patient and everybody else safe. This physical hands-on training will help all of us work together. It has not rolled out yet, but it is in the works. Importantly, this complements another provision for expanding our Code Green Teams—they respond to immediate safety threats in the hospital.

Another crucial victory is that the administration agreed to a campus-wide safety assessment by a third party. That assessment has happened, but we're waiting to hear the recommendations. The hospital set aside $10 million for implementation, and the committee that decides how to allocate the funds will be at least 50 percent employees and up to 25 percent nurses chosen by ONA.

Our union fought through hundreds of hours of negotiations and won our strongest contract ever.

Our focus now is implementation—implementation of our new contract and of the staffing law that Oregon just passed (thanks to fierce advocacy by ONA and other unions).† The law includes accountability mechanisms like fines, but members need to learn what constitutes a missed break, what constitutes a staffing violation, and how to file reports. At ONA's convention in May, there were sessions on the staffing law so that we could learn more about its intention and enforcement. For example, if a friend covers for you so you can take a break, that's not a break violation (you got a break), but it could be a staffing plan violation if there were not enough staff members for safe patient care. No one is supposed to be doubling up on patients, even to cover a short break.

To fully reap the benefits of our new contract, we're doing an internal empowerment campaign to show that workplace violence is not OK and to encourage staff to file reports. Especially in the ED, we encounter violence so often that we become complacent. Through our 10 months of negotiations, we finally got the administration's attention, so now we must document all incidents—and all staffing violations. We've demonstrated our power at the bargaining table; now we have to support each other to file our reports, enforce every detail of the contract, and make OHSU the safe, well-staffed hospital that our patients deserve. ✚

*For a short summary of what we won, see go.aft.org/4xe. To review our contract, visit go.aft.org/pv8.

†To learn more about this staffing law, see "Empowering Nurses in Oregon" in the Spring 2024 issue of *AFT Health Care*: aft.org/hc/spring2024/cline.

Nursing on the Frontier

Creating a Better Life for Patients in Rural Montana

By **Vicky Byrd**

Vicky Byrd, MSN, RN, is the chief executive officer of the Montana Nurses Association (MNA). She began her career in 1989 as a certified pediatric oncology nurse, then transitioned to nurse leadership in MNA. Her priorities are advocacy for professional nurses in Montana and issues affecting professional nurse practice and the health of Montana residents.

I've been a registered nurse for 35 years. I have raised my family and worked my entire career in Montana. I started out as a staff nurse in pediatric oncology and was very active in my union, serving as a union rep, as the local union president, and then as a member of the state board of the Montana Nurses Association (MNA), the professional association for registered nurses and advanced practice registered nurses in Montana. I became the CEO of MNA nearly 10 years ago to better advocate for our nurses so they can better advocate for our patients.

Montana is one of the nation's most rural states, with over 45 percent of our total population estimated to live in census areas of fewer than 5,000 people.* There are significant health challenges associated with rural living, such as higher incidence of disease and injury, decreased access to healthcare, and higher rates of preventable hospitalizations.[1] Most of our counties (52 of 56) have been designated as "medically underserved."[2] For the nearly 500,000 people living in these rural areas, there are fewer than 200 healthcare facilities.[3] Ten counties have no physician.[4]

That's why our nurses, and MNA, are so important. MNA represents 3,300 nurses and 90 percent of the nurses belonging to 29 unions of varying sizes across the state—from a union of about 700 nurses in a facility in Missoula to a union of just two nurses in Forsyth (which has a population of 1,600). We have public and private acute care nurses and clinic and staff nurses. Our most recent local unit is exclusively advanced practice registered nurses (APRNs). Many of our nurses work in rural areas and areas typically called "frontier," which are even more remote, sparsely populated, and isolated from public services—and sometimes do not have a hospital.[5] I've spent the past decade listening to them and bringing their issues forward across the state.

Rural nursing is much different than nursing in urban and suburban areas. In Montana, all RNs and APRNs function under their own licenses. APRNs are

*To learn more about the criteria government agencies use to determine rural status, see ruralhealthinfo.org/topics/what-is-rural.

PHOTOS COURTESY OF MONTANA NURSES ASSOCIATION

not supervised by physicians; rather, they are primary and specialty care providers with full practice authority and prescriptive authority. Because many Montanans live in areas where there is no physician and limited healthcare services for dozens of miles, APRNs' full practice authority is essential for access to care.

Among the reasons our nurses choose to work in rural areas is that they want to care for patient populations that are radically underserved. Our nurses love the autonomy of their work and their breadth and scope of practice. They are highly qualified and provide excellent patient care, with many APRNs running their own clinical practices. Yet, there are significant challenges.

Challenges of Rural Nursing

Perhaps the most significant challenge is that rural healthcare facilities have limited staff. Patients who need healthcare in these areas typically don't see specialty providers; many times, there's just one physician or other clinician on call. It is common for emergency rooms and critical access areas throughout the state to be staffed by RNs and APRNs with minimal additional staff. Patients who need additional medical care must be transported to the nearest larger facility, often up to two hours away, via rural transport teams, paramedics (if they exist), or volunteer ambulances.

A nurse may be the only clinician on shift when suddenly they get a patient who has sustained a trauma, a patient in labor, a patient who has overdosed, or a patient who is having a heart attack. No matter the crisis, the nurse must be a "jack of all trades" with expertise to care for each of these patients. Nurses triage as best they can, and they have systems and processes to help them—but it's challenging for even the most experienced nurse to stay competent to care for patient needs that vary so widely and may sometimes be beyond their training.

Rural hospitals are also limited in critical care services. As an example, my son was living in the very rural town of Cut Bank when he needed care for appendicitis. He was seen by an APRN but needed surgery, which was not available in that facility. The APRN quickly referred him to a facility in Great Falls, 90 minutes away, and he drove there for his surgery. Of course, a patient having a heart attack can't drive 90 minutes away for care. Some facilities have fixed-wing aircraft or helicopters to address this challenge—and there are resources like telehealth that clinicians use to consult with other clinicians—but it's critical that nurses know which resources are available and where to send patients for the care they need.

The challenges of under-resourcing of staff and services are compounded by the state's continual attempts to encroach on and chip away at our nurses' scope of practice. Research shows that the primary and specialty care that APRNs provide is comparable to or better than that delivered by physicians[6]—and APRNs have practiced independently of physician supervision for 45 years in this state. Still, legislators and administrators, some without backgrounds in healthcare or nursing, place physicians on a hierarchy above nurses in efforts to dictate how nurses practice.

APRNs fought hard to get full scope of practice and practice authority passed into Montana law. But in the 2023 legislative session, a Republican legislator introduced a bill requiring physician supervision of APRNs.[7] Fortunately, the bill died in committee; this would have had particularly devastating impacts in our rural and frontier communities.

Staffing shortages are also contributing to workplace violence, which continually threatens patient care and our nurses' well-being. We know that patient outcomes improve with higher registered nurse staffing levels.[8] Yet hospitals continue to understaff, raking in profits while nurses sacrifice (in one instance, our nurses voluntarily froze their wages to keep one of our facilities open). We also know that the workplace should be a safe environment, but violence against nurses and other healthcare workers is severely underreported. There are few legal mechanisms in place to hold employers accountable, including by reporting incidents and supporting those who experience or witness violence. Some of our lawmakers don't think workplace violence really happens; worse, some believe dealing with violence should just be an expected part of a nurse's job.

These and other issues are why many of our nurses are exhausted, overwhelmed, and burned out—and why more nurses are joining MNA. We routinely receive calls from nurses across the state who need support or want to advocate for change in their workplaces and for their patients. Many call because they see the good work we've done for their colleagues at other facilities. That's what led to a unit of 15 APRNs voting to join a union for the first time in Montana history.

At our Montana State Hospital, APRNs have seen for years how MNA helps nurses advocate for themselves and their patients and win better compensation, improved staffing practices, and Weingarten rights, among other victories. Understaffed, overworked, and underpaid, many APRNs were ready to leave. They needed a voice through which they could advocate for appropriate patient care and a fair arbitration process. Now, they have that voice. And together we are fighting for the conditions they need to best serve our rural communities.

What We're Fighting For

Nurses want what patients need, so we need to invest in our nurses. That's the purpose of Retain Me, MNA's Code Red campaign† that focuses on recruiting and retaining nurses. Our aim is to increase awareness

Our nurses choose to work in rural areas to care for patient populations that are radically underserved.

†To read about other AFT affiliates' Code Red campaigns, see *AFT Health Care*'s archive: aft.org/hc/subject-index#code-red.

about the challenges nurses are facing and create the changes needed to address them so that more nurses want to join—and stay on—our care teams.

Our campaign priorities are staffing and workplace violence. Healthcare facilities and state legislators remain reluctant to embrace staffing ratios and other mechanisms to keep nurses from burnout associated with understaffing. So we're actively pursuing both bargaining and legislative solutions. We have bargained safe staffing measures into our contracts—all contracts now include professional conference committees where nurses can take up staffing issues. And we introduced a staffing bill in 2023; it did not pass, but we will continue fighting for legislation that gives our nurses the resources they need, whether they're the only clinician in a facility or not.

While it's unrealistic to expect a 1:4 ratio in rural areas like Forsyth, we need a staffing process that supports nurses when multiple patient crises suddenly arise. Larger facilities have more resources, so there we are fighting for a 1:4 ratio on medical floors and a 1:2 ratio in staffed intensive care units. But we know that it's not enough to fight for set ratios; we must also consider patient, facility, and nurse acuity, which vary significantly.

In the 2023 legislative session, we won mandatory reporting for workplace violence so that any Montana healthcare worker who is assaulted at work has a process for reporting it. Our goal is to ensure that all victims and witnesses of violence have an avenue for pursuing justice, but the first step is making sure that employers are collecting and retaining that data. We'll use the data to push for additional legislation that keeps all of our healthcare workers safe. This is an ongoing fight, but we have the support of hospitals, the medical association, and physicians, and we're confident we'll win as we keep pressing forward.

As we work to make life better for our nurses and patients, we ultimately make life better for all of us.

Those are just a few of our campaign's offensive strategies; we are also employing defensive strategies to protect our nurses' ability to practice to the full extent of their licensure and to organize.

We continue to fight attempts to narrow nurses' scope of practice and to communicate throughout our state and beyond the message that these attempts do not best serve our patients. In 2019, Montana passed legislation giving APRNs signature authority for patient documents that previously required a physician signature. Despite this law, some healthcare facilities and insurance companies refused to recognize APRNs' authority to sign forms with signature lines designated "Physician signature only." We advocated for and won updated language so that those lines now say "Primary care provider."

We are also fighting anti-union bills targeting our nurses. In the last two legislative sessions, we've faced down a Republican lawmaker (who is a nurse!) who has introduced so called right-to-work bills.[9] She was so intimidated when MNA showed up to testify in opposition that she couldn't even present her own bill. Although we have beaten back her efforts thus far, we're expecting her to make another attempt. And we have a state workforce advocacy team of RNs and APRNs ready to be mobilized when needed to call and write to legislators or engage in immediate action on this and other issues.

After 35 years in nursing—including a decade leading MNA—I've only become more convinced that nurses cannot do this work alone. That's why we need unions. Together, we can solve the challenges nurses face, freeing them to focus on our patients. Through our autonomy and our advocacy, MNA is helping nurses keep patients at the forefront. And the numbers of nurses who continue to join us and the AFT family in this work give me hope that as we work to make life better for our nurses and our patients, we ultimately make life better for all of us.

When we take our members' issues to employers, I tell them, "Of all people that you want to walk through your doors, you want it to be MNA. We have your best interests at heart. We want you to succeed in caring for our patients and communities. We just need you to take care of the nurses who care for those patients." I tell lawmakers and those who aren't healthcare workers that if they removed everyone but nurses from our facilities, nurses would manage to keep the doors open. But the reverse is not true: a facility without nurses would have to close its doors. Nurses are the most valuable asset of any facility—and MNA is their biggest advocate in Montana. Whatever our nurses need, we're going to help. And our collective voice is very, very powerful. ✚

For the endnotes, see aft.org/hc/fall2024/byrd.

Bigger Med

Consolidation's Devastating Impact on Patients and Workers

By Dan Arnold

Dan Arnold, PhD, is a health economist at the University of California, Berkeley, School of Public Health, where he also serves as the research director for the Nicholas C. Petris Center on Health Care Markets and Consumer Welfare.

Surgeon, writer, and public health researcher Atul Gawande wrote an article in 2012 titled "Big Med."[1] The article was about how medicine was finally starting to fall to the big corporate chains, just like restaurants, hotels, and soft drinks had. After years of physicians being predominantly self-employed—working alone or in small private practices—physicians started signing up to be employees of large health systems.

But in many ways, 2012 was still a simple time in terms of healthcare bigness. From 2012 to 2022, the share of physicians working in private practices fell from 60 percent to 47 percent.[2] Back in 2012, private equity had little interest in healthcare; across 10 physician specialties, there were only seven metro areas in the United States where a private equity firm had greater than 30 percent market share. By 2021, that number was 108—or nearly a third of all US metro areas.[3]

In 2012, Amazon had no healthcare presence and UnitedHealth was just a health insurance company. Today, Amazon is a significant player in primary care and pharmacy markets via its acquisitions of One Medical and PillPack; by the end of 2023, UnitedHealth had nearly 90,000 employed or affiliated physicians through its Optum subsidiary.[4]

The purpose of this article is to detail how much bigger US healthcare corporations have gotten and to explain the impact this has had on patients and workers. Healthcare consolidation—and hospital consolidation in particular—has negatively impacted not only the wages of nurses but also the wages of all workers, even those who are not health professionals. But we'll get to that later. First, let's take a stroll through what health economist Uwe Reinhardt referred to as America's healthcare wonderland.[5]

The Paycheck Gobbler

It seems everything is more expensive these days. Inflation was stable at around 2 percent a year from 2014 to 2020, but then rose rapidly to 9 percent in June 2022.[6] Inflation eats away at the purchasing power of consumers. Ideally, wages and investment income outpace inflation. If they don't, then consumers' purchasing power falls.

But not everything gets more expensive over time. Notably, high tech products consistently get cheaper. TV and computer software prices have dropped 60 to 90 percent since 2000. What price has increased the most since 2000 among the typical products and services households consume? Hospital services: they are up over 200 percent. The price of medical care services (e.g., doctor visits) increased 120 percent over the same time period. Compare these to wages and inflation over this period, which increased 87 percent and 60 percent, respectively.[7]

There always seems to be a concern about Americans getting priced out of housing. But compared to healthcare, housing's 70 percent price increase over the period looks paltry.[8] There's no doubt about it: healthcare is gobbling up our paychecks.

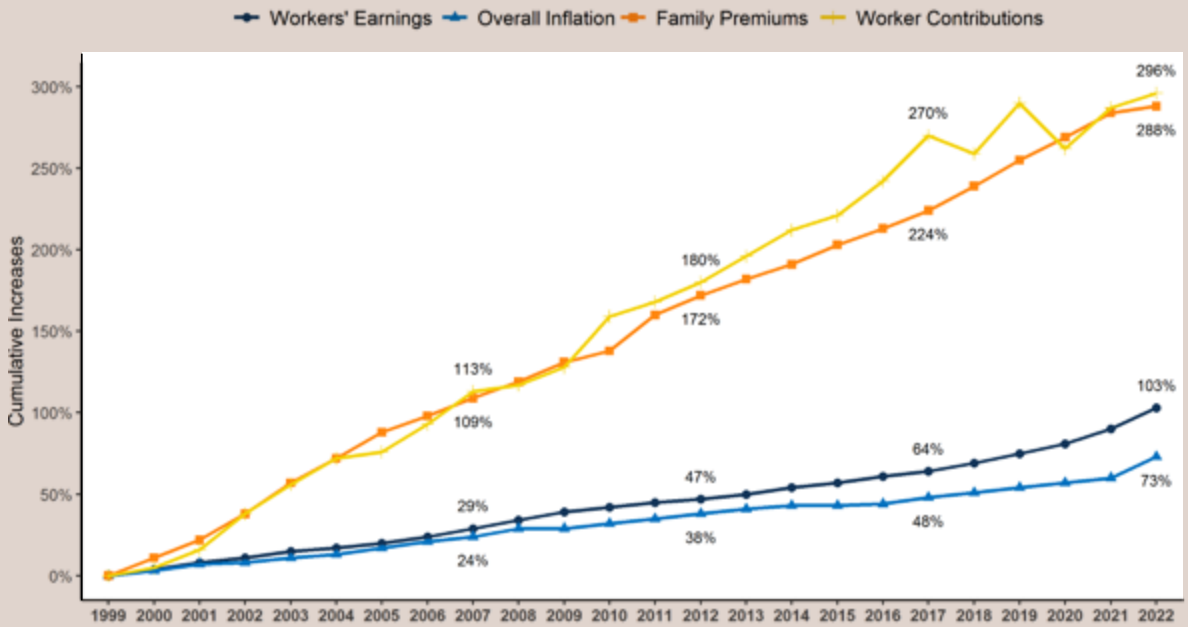
To make the healthcare dent in take-home pay abundantly clear, take a look at the first chart on page 14, which shows workers' earnings, inflation, family health insurance premiums, and workers' contributions to family premiums from 1999 to 2022. Workers' earnings have outpaced inflation since 1999 (an

ILLUSTRATIONS BY CARLO GIAMBARRESI

increase of 103 percent versus 73 percent)—that's the good part. But over the same period, family premiums increased nearly 300 percent and worker contributions to family premiums increased in lockstep, also up nearly 300 percent. As healthcare gets more expensive, health insurance premiums increase to cover the extra costs, and you and your employer bear the burden.

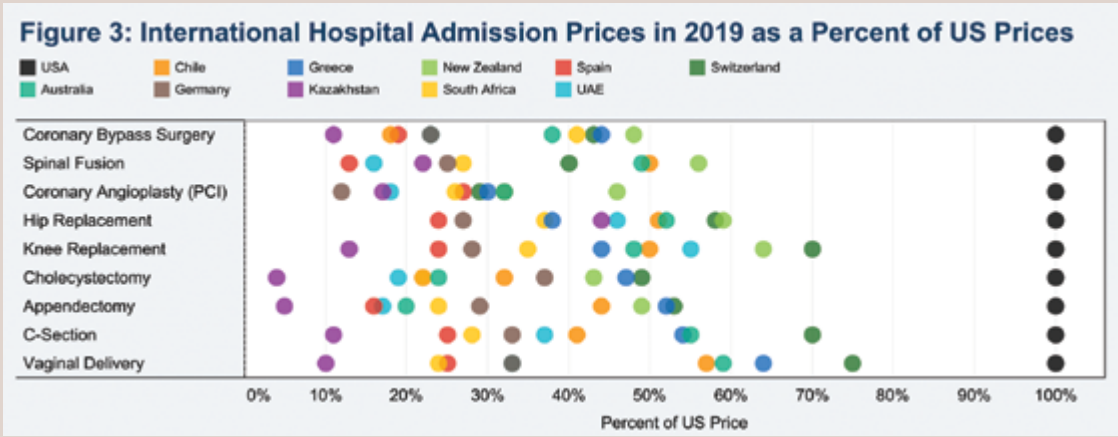
A shocking study from 2019 estimated that 67 percent of all personal bankruptcies in the United States from 2013 to 2016 were tied to medical issues—because of high costs for care or time out of work.[9] And a 2024 analysis found that among US adults, 8 percent have medical debt and 1 percent have more than $10,000 in medical debt. The situation is worse for those who are in poor health, have a disability, or have an income below 200 percent of the federal poverty line: 20, 13, and 11 percent, respectively, have medical debt.[10]

Cumulative Increases in Family Premiums, Worker Contributions to Family Premiums, Inflation, and Workers' Earnings, 1999–2022



SOURCE: KFF Employer Health Benefits Survey, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation, 1999-2022; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1999-2022.

International Hospital Admission Prices as a Percent of US Prices, 2019



Our Unique Price Problem

So, healthcare costs are eating up a greater share of people's paychecks and are burdening a number of them with medical debt. But is this a uniquely American problem? Healthcare prices generally increase relative to TVs and computer software worldwide, so that part is not uniquely American. But US healthcare is still unique.

It is widely known that the United States spends more on healthcare than other countries—a lot more. The question has always been *why*? As countries become wealthier, they generally spend more on healthcare. Once you've covered the basic necessities of life, spending extra income on trying to extend the length and quality of your life makes sense. But we spend twice as much per capita as other large, *wealthy* countries. What gives?

A group of health policy researchers gave what they believed to be the answer in the title of their 2003 paper, "It's the Prices, Stupid: Why the United States Is So Different from Other Countries."[11] A lot of research since 2003 supports the authors' conclusion: we have a healthcare price problem. The second figure on page 14 shows the prices of nine common hospital admissions for the United States and 10 other countries. For all nine admissions, our price is well above the prices in other countries—often two to five times above.

Why the High Prices?

Healthcare in America relies on competition to function. Ideally, more competition means lower prices, higher quality, more product variety, and greater innovation. But the healthcare industry is trending toward more consolidation and less competition.

We could examine a lot of different healthcare prices, but let's focus on hospital prices for the moment. Often when high US hospital prices are being discussed, it is implicitly commercial hospital prices that are being referred to. Commercial prices (as opposed to Medicare or Medicaid prices) are those paid to hospitals by employer-sponsored health plans. The prices in the second figure on page 14 are commercial hospital prices. Medicare and Medicaid prices paid to hospitals are administratively set by the government. Commercial prices, on the other hand, are agreed upon through bilateral bargaining between insurers and hospitals. During bargaining, each side tries to use whatever leverage it has to negotiate favorable rates. Insurers want low hospital reimbursement rates; hospitals want high rates. What happens in a market where there are five insurers and one hospital? The hospital has a lot of leverage because it has five insurers it can contract with. But the insurers must either contract with the one hospital or not participate in the market. What if the reverse were true? One insurer and five hospitals. Then the leverage flips. The one insurer now has the leverage to force the five hospitals to compete over inclusion in its network.

This bargaining is why mergers matter in the context of hospitals (and healthcare generally). Suppose market A has two insurers and two hospitals to begin with. Then the two hospitals decide to merge. In the original situation, the insurers at least had two options and could try to play the hospitals against each other for network inclusion. Once the hospitals merge, there is no longer any other option for the insurers and the merged hospital has the leverage to negotiate higher reimbursement rates. This dynamic is at least partially responsible for the rise in hospital prices in recent years.*

Hospital mergers are driving prices up, failing to increase quality, and driving wages down.

Between 1998 and 2021, 1,887 hospital mergers were announced, reducing the number of US hospitals from around 8,000 to a little over 6,000.[12] Hospital mergers have been studied more by health economists than any other type of healthcare consolidation, so we have a pretty good idea of what they lead to.[13] It is clear that they increase hospital prices and spending. Their impact on quality is mixed, and they tend to decrease healthcare wages, particularly nurses' wages.

Estimated hospital price increases "of 20 or 30 percent are common, with some increases as high as 65 percent."[14] Three retrospective merger analyses conducted by the Federal Trade Commission—the Evanston Northwestern and Highland Park merger in the Chicago area, the Sutter and Summit merger in the San Francisco Bay Area, and the merger of the Cape Fear and New Hanover hospitals in Wilmington, North Carolina—found price increases of 65 percent, 44 percent, and 65 percent, respectively.[15]

Merging hospitals typically claim that the merger will increase efficiency and improve quality. There is a care coordination reason to suspect quality could improve after hospital mergers. But so far, documenting quality increases has eluded researchers. The study of the impact of hospital mergers on quality with the strongest methodology (in my opinion) was published in 2020. Using data from 2007 to 2016 that included 246 acquired hospitals, the study found that hospital acquisition was associated with modestly worse patient experiences and no significant changes in readmission or mortality rates.[16]

The impact of hospital consolidation on wages is most easily seen through its impact on nurses' wages. If a market is served by one seller, the seller is said to have a monopoly. It is less common to hear the term *monopsony*, which is the term used when a market has one buyer. A monopoly hospital is the only provider (seller) of hospital services in a region. A monopsony hospital is the only buyer of nurses' labor. The same hospital can

*Hospital prices are influenced by multiple factors. This is a simplified discussion to demonstrate that consolidation gives hospitals a lot of pricing power by taking away insurers' other alternatives.

Three analyses of hospital mergers found price increases of 44 to 65 percent.

be both a monopoly in terms of the services it sells and a monopsony in terms of the labor it buys. This would be the case if there were no good treatment alternatives to the hospital and nurses had no good employment options aside from the hospital. Among economists, the former has generally been thought to be true (it's hard to imagine going somewhere other than your local hospital to get a hip replacement). The latter has been more of a debate. Nurses could go work for doctors' offices or find a job outside the field of healthcare entirely, but if they want to utilize their specialized training, it is generally hospitals that most demand the types of specialized services that nurses can provide.

Several papers have discussed how monopsony power of hospitals can hold down the wages of nurses, but I'll focus on one from 2021 that's among the most recent and has the strongest methodology. Examining US hospital mergers between 1998 and 2012, the authors found that in markets with large increases in hospital concentration, wages were 7 percent lower for nursing and pharmacy workers compared to the wages of nursing and pharmacy workers in markets that were not exposed to hospital mergers. In terms of wage growth, this implied that post-merger annual wage growth was 1.7 percentage points slower for nursing and pharmacy workers than would be expected absent the merger. The authors also found that wage growth slowdowns were attenuated in markets with strong labor unions.[17]

Hospital mergers reduce wage growth for nurses—but less so in places with strong unions.

Equally important, all this consolidation indirectly impacts everyone, even those who rarely use medical services and aren't health professionals. Everyone with employer-sponsored health insurance is exposed to cost increases created by healthcare mergers. Hospitals merge, the costs of hospital services go up, health insurance premiums go up to cover the costs, and workers and employers are on the hook for those higher premiums. Employers then have a choice: bear the additional costs by themselves or lower workers' wages (or reduce their wage growth). There are health insurance benefit decisions they can make as well, such as offering health plans that have higher deductibles, but those are just additional ways of making workers bear the added costs.

A recent study I conducted with Chris Whaley, a health economist at Brown University, analyzed the impact of hospital mergers on the wages of nonhealthcare workers. Their wages should only be affected by hospital mergers through the impact the mergers have on their health insurance premiums, deductibles, and other out-of-pocket costs. We found that hospital mergers lead to a $638 reduction in wages, a $521 increase in hospital prices, and a $579 increase in hospital spending among the privately insured population (indicating employers were shifting funds from wages to insurance costs).[18]

Making matters worse, private equity is now accelerating the hospital consolidation trend. The Private Equity Stakeholder Project tracks private equity–owned hospitals in the United States and shows 460 such hospitals as of January 2024. This represents 22 percent of the United States' proprietary for-profit hospitals. Texas has the most with 97, and New Mexico has the highest proportion, with private equity owning 38 percent of private hospitals in the state. Nearly a quarter of private equity–owned hospitals are psychiatric hospitals. Almost all of this private equity hospital acquisition activity occurred in the last decade.[19] A recent study comparing almost 700,000 hospitalizations across 51 private equity–acquired hospitals with four million hospitalizations across 259 matched control hospitals found that private equity acquisition was associated with a 25 percent increase in hospital-acquired conditions.[20] Another study found private equity hospital acquisitions to be associated with large increases in net income, charges, and charge-to-cost ratios.[21] (For more on private equity's tactics and impact, see the sidebar on page 17 and the article on page 18.)

These trends are clearly in the wrong direction. We should be moving toward more accessible and affordable care, along with improved conditions for healthcare workers. Individually, there's little we can do to change the direction of the healthcare industry. But together, as union members and voters, we can rewrite the rules.

What Can Be Done?

Reversing these trends will not be quick or easy—but it can be done. The first two ideas that pop into many people's minds are to (1) set prices administratively like in Medicare and Medicaid or (2) move the whole US healthcare system to a single-payer system like that of the National Health Service in the United Kingdom. Both ideas, while appealing in some ways, are problematic[22] and are politically unlikely to happen (at least in the foreseeable future). Still, there's much that we can do without achieving a complete overhaul of our healthcare system.

Let's start with promoting competition. The US Department of Justice (DOJ) and the Federal Trade Commission (FTC) have been more aggressive of late in challenging mergers. In September 2023, the FTC sued US Anesthesia Partners (the principal provider of anesthesia services in Texas) and private equity firm Welsh, Carson, Anderson, and Stowe, alleging the two executed a multiyear, anticompetitive scheme to consolidate anesthesiology practices in Texas, drive up the price of anesthesia services provided to Texas patients, and boost their own profits.[23] In May 2024, a judge dismissed the FTC's case against Welsh, Carson, Anderson, and Stowe but allowed the case to continue against its portfolio company, US Anesthesia.[24] While the first cases brought against private equity firms will face hurdles like this, I'm optimistic that today's DOJ and FTC will be more willing to bring these types of cases than they were in the past.

In March 2024, the DOJ and FTC, along with the US Department of Health and Human Services (HHS), requested public comment on the impact of corporate greed in healthcare. In the press release, FTC Chair Lina Khan said, "When private equity firms buy out healthcare facilities only to slash staffing and cut quality, patients lose out. Through this inquiry the FTC will continue scrutinizing private equity roll-ups, strip-and-flip tactics, and other financial plays that can enrich executives but leave the American public worse off."[25] HHS Secretary Xavier Becerra emphasized that increased competition in healthcare markets would improve the cost and quality of care and also boost worker wages and conditions. This shows there is an appetite at the federal level under the Biden-Harris administration for curbing healthcare consolidation.

States are also showing an appetite. California established the Office of Health Care Affordability in 2022. One of its primary tasks is to assess market consolidation in the state by collecting material change notices and conducting cost and market impact reviews when transactions "are likely to significantly impact market competition, the state's ability to meet targets, or affordability for consumers and producers."[26] This effort follows similar efforts in other states, most notably Massachusetts and Oregon.[27]

There are also things employers and unions can do. Employers should be more involved in deciding which providers are in the networks of the health plans that they offer employees. By wanting every provider in network, employers make it difficult for insurers to use the threat of network exclusion on hospitals, which takes away much of the leverage insurers could have in price negotiations.

One crucial role of unions—and workers—is emerging from research on the impact of hospital mergers on nurses' wages. Hospital mergers reduce nurse wage growth, but this effect is mitigated in markets with strong unions.[28] Unions are an important counterforce to the wage stagnation generated by healthcare mergers—and the more people join, the greater union power will be.

Another role of unions is organizing and mobilizing to advocate for legislative and regulatory changes. Nurses, doctors, and others who work in healthcare are often trusted in their communities, and they can build on that trust by ensuring their patients, families, and community members know about the risks of consolidation. Electing leaders who are supportive of what the DOJ and FTC are doing under the Biden-Harris administration's direction and what states such as California, Massachusetts, and Oregon are doing will help curb healthcare consolidation and, in turn, benefit patients and workers. The road is long, but there are signs of progress. ✚

For the endnotes, see aft.org/hc/fall2024/arnold.

Healthcare workers can alert patients, families, and communities to the risks of consolidation.

Private Equity

Over the past decade, private equity firms* have invested in, acquired, and consolidated healthcare facilities at an astonishing rate. From 2018 to 2022 alone, global healthcare buyouts by private equity firms were about $450 billion.[1] Over the last five years, healthcare deals (beyond just hospitals) have accounted for 15 to 21 percent of total private equity deals.[2]

Private equity firms typically use capital from institutional investors and high net worth individuals, along with large amounts of debt, to acquire companies. They usually seek to sell their holdings within three to five years for significant returns.[3]

Hospitals, physician practices, fertility clinics, nursing homes, and hospice facilities have all been targeted by private equity.[4] The number of deals across 10 physician specialties increased from 75 in 2012 to 484 in 2021—a six-fold increase within a decade.[5] For fertility clinics, a 2020 study found that private equity's involvement in women's healthcare accelerated starting in 2017,[6] and a 2021 study estimated that 15 percent of fertility clinics had a private equity affiliation.[7] A 2021 study looking at nursing homes identified 79 private equity deals covering 302 nursing homes across 37 states.[8] And a 2023 study found that the portion of Medicare hospice patients in private equity–owned facilities increased from 5 percent in 2013 to 14 percent in 2021.[9]

A recent systematic review of the impact of private equity ownership on healthcare operators was not positive.[10] The review included 55 studies across eight countries, with the majority (47) of the studies focused on the United States. From nursing homes and dermatology to gastroenterology and orthopedics, the review concluded that private equity ownership was most consistently associated with increases in costs to patients or payers. It also found mixed to harmful impacts on quality with reduced nursing staff levels or a shift toward lower nursing skill mix. The review did not identify any consistently beneficial impacts of private equity ownership.

It's worth spending an extra moment on one of the private equity nursing home studies included in the review. This study found that private equity ownership increased mortality by 11 percent.[11] That's about as bad as it gets in terms of a quality outcome. The increase in costs to patients or payers isn't good, but it's perhaps unsurprising. The increase in mortality—arguably the most important of all quality measures—is shocking. The authors state that "declines in measures of patient well-being, nurse staffing, and compliance with care standards help to explain the mortality effect." This is just one study, but the possibility of these types of results should have all of us nervous about private equity's move into healthcare.

–D. A.

For the endnotes, see aft.org/hc/fall2024/arnold_sb.

*For a deeper exploration of private equity's predatory tactics in healthcare and the devastating effects, see "How Private Equity Has Looted Our Hospitals" on page 18.

How Private Equity Has Looted Our Hospitals

And What We Can Do to Stop It

By **Mary Bugbee**

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In January 2024, the *Boston Globe* reported the tragic story of a new mother who died in October 2023 after the embolization coil needed to treat her post-birth bleeding was unavailable at the Massachusetts hospital where she gave birth. The coil had been repossessed weeks before by the medical device company that owned it because the hospital had not paid its bill. The hospital in question was Steward Health Care's St. Elizabeth's Medical Center.[1]

The year before, another Steward hospital—Rockledge Regional Medical Center in Florida—had experienced an infestation of thousands of bats.[2] The fifth-floor intensive care unit (ICU) reportedly reeked of bat guano,[3] and an ICU nurse found a bat clinging to one of the curtains.[4] One ICU patient complained of being attacked by a "giant grasshopper," which turned out to be a bat.[5] Steward hired an extermination company to address the issue, and within months that company sued the hospital over an alleged $1.6 million in unpaid bills and related costs.[6]

Stories of Steward Health Care's deteriorating finances and hospitals began to pile up in local media coverage. By early 2024, Steward, a for-profit healthcare system that was owned by private equity firm Cerberus Capital Management from 2010 to 2020,[7] was drawing significant national attention.

In April 2024, Massachusetts Senators Edward Markey and Elizabeth Warren held a field hearing in Boston, where they and the various witnesses called to testify criticized the private equity investors who had looted Steward Health Care and left its hospitals on the brink of ruin.[8] In that moment, criticism and the promise to introduce legislation preventing another situation like this were the only weapons the legislators could wield. Much of what the private equity investors and their accomplices got away with involved legally permitted business practices.

Steward filed for Chapter 11 bankruptcy in May 2024.[9] The system reported over $9 billion in liabilities in its bankruptcy filing, which included almost $1 billion owed to vendors and medical suppliers and $6.6 billion in long-term lease obligations to its hospital landlord, Medical Properties Trust.[10] Steward's bankruptcy is one of the largest hospital bankruptcies in decades.[11]

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Private equity has increasingly shown up in media coverage about struggling hospitals in the United

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States, leading to heightened scrutiny from state and federal legislators and regulatory agencies.[12] But what exactly is private equity? And how is it different from other types of corporate healthcare that have attracted ire for putting profits before patients?

Private equity is a type of alternative investment that uses money from pension funds, foundations, and other large investors. These investments are typically not publicly traded (hence "private" equity), so there is relatively little transparency around them. The opacity makes it easier for private equity to make investment decisions that can enrich a few at the expense of many.

Private equity investment usually works like this: a private equity firm opens a fund and raises money for this fund from institutional investors, like pension funds and foundations. The firm uses the fund, alongside debt, to purchase multiple companies—then tries to cut costs and increase cash flow at these companies so as to sell them at a profit roughly three to seven years down the road.[13] The private equity firm generally has control of the investments, even though most of the money it invests belongs to others. The firm also takes home a disproportionate share of any profits (about 20 percent) from the fund, despite investing little of its own money (around 2 percent or less).[14]

Private equity has become an increasingly powerful force in the global economy. As of June 2023, private equity firms controlled $13.1 trillion in assets, a number that has been rising nearly 20 percent annually since 2018.[15] In the US healthcare sector alone, private equity has invested over $1 trillion in the last decade.[16]

Private Equity and Healthcare

The healthcare sector of the US economy has long been favored by private equity firms because there is growing demand for healthcare services thanks to a population that not only is aging but also has a high disease burden. There are also many subsectors within healthcare—such as outpatient specialty care, home health and hospice care, and clinical research—where firms see opportunities for consolidation.[17] Consolidation, or gaining greater market share by acquiring multiple companies and rolling them up into one big company, can generate profits for private equity investors hoping to sell the company down the road. This does not translate to cheaper or better care for patients; the available evidence shows that consolidation among healthcare providers drives up the cost of care with little or no improvement—indeed, some studies show declines—in the quality of care.[18]

Putting profits before patients is not unique to private equity–owned healthcare companies. But because there's less transparency around private equity deals and the companies they own, and because private equity firms tend to use more debt than other types of investors to fund their business strategies, the private equity business model can amplify the profit-seeking behaviors that put patients and healthcare workers at risk.

At least 8 percent of all private hospitals—and 20 percent of all for-profit hospitals—in the United States are now owned or operated by private equity firms.[19]

The Private Equity Hospital Business Model

Debt is a fundamental part of the private equity business model and one of the main reasons private equity acquisitions of hospitals can be so harmful to workers and patients. Private equity firms often use leveraged buyouts to acquire companies, which involves financing a substantial portion of the acquisition by taking out debt secured by the company it is buying. This means that the debt doesn't belong to the private equity firm and its investors—it's instead saddled onto the company being acquired, such as a health system or hospital. In a leveraged buyout, 60 to 90 percent of the transaction will typically be funded by debt,[20] and the health system, not the investors, will ultimately be on the hook for this debt. This may sound confusing or seem like the kind of thing that shouldn't be allowed. But it's perfectly legal.

Private equity has invested over $1 trillion in the US healthcare sector over the last decade.

Steward Health Care came into existence via a leveraged buyout in 2010, when private equity firm Cerberus Capital Management purchased Caritas Christi Health Care, a Catholic nonprofit health system based in Massachusetts. Cerberus rebranded the health system as Steward Health Care and converted its status from nonprofit to for-profit.[21]

Because of the health system's conversion to for-profit status, the deal required approval from the state attorney general's office, which imposed a five-year monitoring period and multiple conditions on the transaction. These conditions included a requirement for the new owners to invest $400 million into the system's infrastructure.[22] Despite Cerberus Capital's deep pockets, these "investments" came from debt loaded onto Steward as well as from selling off the real estate of some of its medical office buildings.[23] Although the initial purchase price was just $420 million, these conditions pushed the total purchase price to $895 million—but Cerberus only put up $246 million in equity for the transaction.[24]

In addition to the initial leveraged buyout, private equity firms often use debt to fund expansion. Inves-

tors will direct the health system to take on more debt so it can acquire more hospitals, physician practices, and other ancillary businesses. This is what happened with Steward Health Care. After its monitoring period in Massachusetts was over, Steward embarked on a rapid debt-funded expansion strategy by buying up other hospitals and rolling them into the same corporate chain. Steward eventually grew to be the largest private hospital system in the United States, even as many of its hospitals were struggling.[25]

Cutting Costs and Increasing Revenues

A health system that's loaded down with debt has to pay its debt service obligations—principal and interest—each month on top of all the usual costs of running a hospital. When the debt burden is high, the health system has added pressure to increase revenues and cut costs. There aren't many ways to cut costs in healthcare without impacting patients and workers.

Private equity firms borrow money to buy up hospitals, but the burden of that debt falls on the health systems—not the investors.

Common cost-cutting practices used by private equity investors in hospitals include understaffing, relying on cheaper staff with fewer qualifications, skimping on healthcare supplies, and delaying important capital improvements, like equipment and building maintenance. Some systems have even delayed payments to vendors or failed to pay staff on time. And most tragically, some systems have cut critical services or closed entire hospitals, leading to layoffs of workers and reduced access to care for entire communities.[26]

Researchers have been empirically examining the impacts of private equity investments in healthcare. A recent peer-reviewed study demonstrated that private equity acquisition of hospitals was associated with a 25.4 percent increase in hospital-acquired conditions, including falls and bloodstream infections.[27] A 2023 systematic review of the research on private equity ownership and its impacts on health outcomes, costs, and quality found that private equity ownership was associated with reduced nurse staffing levels.[28]

Under Cerberus Capital's ownership, Steward's Massachusetts hospitals faced numerous unsafe staffing complaints from the local nurses' union[29] and saw higher than average patient hospital-acquired infections, falls, and readmissions.[30]

In 2014, Steward moved to close Quincy Medical Center in Massachusetts despite commitments it had made to regulators to keep it open.[31] In response, the state attorney general's office required it to keep the emergency room open, while all other services were cut. After selling the hospital to a real estate developer, Steward eventually closed Quincy Medical Center for good in late 2020, leaving the city of Quincy with no emergency room.[32] In Youngstown, Ohio, Steward closed a hospital in 2018 just a year after acquiring it, laying off 388 workers[33] and leaving the city without a labor and delivery unit.[34]

Alongside cutting costs, private equity investors seek to increase revenues. While increasing revenues sounds like a helpful thing for a business, if left unchecked it can lead to putting profits before patients and staff. Hospitals may raise prices or go after unpaid patient bills more aggressively. In fact, the aforementioned 2023 study found an association between private equity ownership and higher costs to patients and payers (i.e., health insurers).[35] Clinicians may be incentivized or required to see more patients per hour and order more expensive tests. Sometimes the pressure to increase revenues can even cross the line into Medicare and Medicaid fraud.[36]

In 2018, Steward was sued for an alleged Medicare and Medicaid kickback scheme. The system ultimately reached a $4.7 million settlement with the US Department of Justice in 2022.[37] In December 2023, the US Attorney's Office filed another lawsuit against Steward regarding allegations of a kickback scheme spanning from 2013 to 2022.[38]

Even a hospital that achieves healthy revenues each year may end up aggressively cutting costs to make its debt payments. For a hospital that operates on much thinner margins, a high debt load can be a death sentence—especially when interest rates go up. What once might have been an affordable monthly payment can skyrocket in a high interest rate environment.

In 2021, interest rates in the United States started to creep up, and by the end of 2022, many debt-burdened private equity–owned healthcare companies were feeling the pain. According to credit rating agency Moody's Investors Service, 93 percent of the most distressed healthcare companies as of November 2023 were owned by private equity firms.[39] One-fifth of healthcare companies that declared bankruptcy in 2023 were owned by private equity firms.[40]

If debt is so risky, why do private equity firms like Cerberus Capital use it to buy and expand hospital systems? Debt means their investors aren't on the hook. Ultimately, the risk that comes with debt is borne by the hospitals themselves because the private equity firms use the hospitals to guarantee the debt. And so private equity firms can treat the debt taken out against their hospitals as free money. They use it to buy the health system, to expand it, and sometimes to even pay themselves dividends (more on this in a bit). But private equity firms have limited liability: they cannot

lose more than the capital they've put in. Therefore, just like parasites that can thrive while their hosts die, they can still make a profit even if the hospital system they own goes bankrupt.

But a savvy private equity firm will exit an investment before bankruptcy transpires. In the case of Steward Health Care, its private equity owners plundered it and sold what was left to a new set of owners. After Cerberus exited, the health system's financial situation continued to deteriorate as the legacy of various financial decisions made by its former owners put it on the path to bankruptcy.[41]

Looting Tactics

There are three particularly parasitic strategies that private equity firms have used with hospitals: dividend recapitalizations, management fees, and sale-leasebacks of hospital real estate. These strategies often increase the debt load on the hospital and burden it with extractive payments that cut into operations.

Dividend Recapitalizations

A dividend recapitalization is, in essence, a misnomer. It sounds like it will make more capital available to the hospital, but it does the opposite. The private equity firm makes the hospital take on new debt in order to provide cash payouts to its private equity investors. Just as in a leveraged buyout, the health system is on the hook for the debt—not the private equity firm. Dividend recapitalizations are a fundamentally extractive strategy in which the health system gets treated like a piggy bank so investors can pay themselves handsomely.

Management Fees

Private equity firms often charge management or advisory fees to the companies they own, which can amount to millions of dollars per year. Fees are typically stipulated in a management services agreement between the private equity firm and the company it controls. In some cases, companies must pay fees to the private equity firm even for services never rendered (called "accelerated monitoring fees"). These fees can further drain a company's cash away from hospital operations and into investors' pockets.

Prospect Medical Holdings is a hospital system that was majority owned by private equity firm Leonard Green & Partners from 2010 to 2021. At its largest, Prospect owned hospitals across California, Connecticut, New Jersey, Pennsylvania, Rhode Island, and Texas. Most of Prospect's hospitals are safety-net hospitals, which are designated to serve low-income, uninsured, and vulnerable populations.[42]

Over the course of its 10-year ownership, Leonard Green & Partners, and Prospect's minority owners, took approximately $9 million in management fees and $649 million in dividends, in part by saddling this safety-net hospital chain with debt and using the proceeds of the loans to pay themselves.[43] They siphoned this money out of Prospect even as many of its hospitals suffered deteriorating financial conditions and serious patient care quality concerns.[44]

Sale-Leasebacks and Hospital Landlords

You can't tell the story of how private equity has looted many US hospitals without mentioning their accomplices: hospital landlords, otherwise known as real estate investment trusts (REITs). In a sale-leaseback transaction, a hospital system splits its real estate from its operations and sells the real estate to a REIT. Selling the real estate generates cash, but much of that goes straight to private equity investors who pocket it for themselves. After the sale, the health system has to pay monthly lease payments to the new landlord on real estate it used to own. Sale-leasebacks replace mortgage payments (or no payments for a property that was paid off) with lease payments and strip the health system of its most valuable asset.

One REIT in particular has played a starring role in recent hospital looting scandals: Medical Properties Trust (MPT). Founded in 2003 and headquartered in Birmingham, Alabama, MPT has worked closely with various private equity–owned hospital systems, including Steward and Prospect, to sell off hospital real estate to enrich investors, often at the expense of the health systems.[45]

After its five-year monitoring period with the Massachusetts attorney general expired,[46] Steward Health Care executed a $1.2 billion sale-leaseback transaction in 2016 with MPT. MPT made an additional $50 million equity investment in Steward, becoming a minority owner of the company.[47] Many Steward hospitals were now on the hook for hefty rent payments, in addition to losing their highest-value asset. This sale-leaseback deal was used to pay nearly $500 million in dividends to Cerberus and help fund Steward's expansion to other states.[48]

Four years later, Steward was financially struggling, but Cerberus wanted to exit its investment. With the hospitals' poor financial position and the pandemic just beginning, selling the company would be difficult. At Cerberus's behest, MPT provided a $400 million cash infusion into the system and a $335 million loan to a group of Steward physicians who would become its new owners, allowing Cerberus to exit.[49]

Despite the cash infusion from MPT and $675 million that Steward received in pandemic relief loans and grants in 2020,[50] the system was still struggling by the time Cerberus fully exited in January 2021, having made at least $800 million in profit in the decade it owned Steward.[51] That month, its new physician owners took out another $111 million in dividends. Chief Executive Officer Ralph de la Torre bought a $40 million yacht later that year.[52]

The role of MPT in the pillaging of Steward cannot be overstated. Without a willing REIT like MPT to abet

Like parasites that thrive as their hosts die, private equity firms can profit as their hospitals go bankrupt.

Steward's asset-stripping and to help its private equity investors exit, Steward would not have been so easily able to generate the millions paid to Cerberus. The rent payments for those hospitals would ultimately burden the system's finances at the expense of operational costs.

In September 2023, state and federal officials declared that patients were in immediate jeopardy at Steward's Good Samaritan Medical Center in Brockton, Massachusetts—where the local nurses' union had been warning officials since 2021 about critical understaffing and major safety issues in the emergency department.[53]

By early 2024, Steward's hospitals were facing a dire financial situation. In January 2024, MPT announced that Steward Health Care was $50 million behind in rent payments.[54] Vendors were suing for unpaid bills[55] and staffing and patient quality of care issues were mounting.[56] Between May 2023 and February 2024, Steward had already closed struggling hospitals or units in Texas[57] and Florida,[58] and in April 2024 it closed New England Sinai Acute Long-Term Care and Rehabilitation Hospital in Massachusetts.[59] Legislators and politicians scrambled to address the system's financial implosion.[60]

When workers fight for each other and their patients, they begin to shift power away from greedy executives and investors.

MPT also had a hand in the pillaging of Prospect Medical Holdings. As mentioned, Prospect's owners, Leonard Green & Partners, saddled the hospital system with millions in debt to fund investor payouts. To pay off this debt, Prospect sold the bulk of its real estate to MPT in a sale-leaseback transaction.[61] The transaction simply replaced the debt with lease liabilities and left Prospect with fewer assets.[62]

In 2021, Leonard Green & Partners exited its stake in Prospect, with the system left in $3.1 billion of debt.[63] And Prospect's hospitals are in serious financial trouble. One of its four hospitals in Pennsylvania had to close in late 2022 due to inadequate staffing, and others have laid off workers or cut critical services.[64]

At Prospect's three hospitals in Connecticut, the financial situation became especially grim in 2023. The hospitals reportedly owed millions to vendors and contract physicians[65] as well as $67 million in back taxes and interest to the state.[66]

Parallel to Steward's situation, lease payments with MPT have contributed to financial distress at Prospect hospitals. As of May 2023, Prospect owed at least $68 million to MPT,[67] and some of its hospitals reportedly missed rent payments to MPT through much of 2023.[68]

It appears that both Cerberus Capital and Leonard Green & Partners have gotten off scot-free. They siphoned hundreds of millions from the Steward and Prospect healthcare systems, adding substantial debt that put hospitals in dire financial condition, then made their exit—leaving patients, workers, and their communities holding the bag.[69]

What We Can Do

The abuses wrought by private equity firms at many of our nation's hospitals are infuriating at best, tragic at worst. What can we do to ensure that private equity pillaging in healthcare comes to a stop—and that Wall Street is held accountable? There are two main ways we can accomplish this: by organizing and by fighting for robust and effective policies.

Organize!

Healthcare workers should always be organizing, whether their hospital is currently private equity–owned or not. A merger or buyout can always be around the corner, and workers should pay attention to how their workplace fits into the broader ecosystem of for-profit healthcare.

When workers come together to educate each other and fight for each other and their patients, they begin to shift the power away from greedy executives and investors. At both Steward and Prospect hospitals, healthcare workers have been playing important roles in exposing harms such as unsafe staffing practices inside their hospitals and in advocating for their patients.[70] Healthcare worker organizing efforts have also extended to their communities. Activities like informational pickets have helped educate community members about the dangers to patients and workers,[71] and building coalitions with community organizations has helped to bring the voices of patients, workers, and community members—those most affected by corporate greed—to the forefront as major decisions are being made.[72]

If you work at a unionized hospital, get involved with your union.* Go to union meetings. Learn and talk with your union siblings about what's going on at your hospital. Support bargaining efforts by joining your union's bargaining committee, participating in bargaining surveys, and attending union-led actions. If you're not yet a member, now is the time to join.

Pension funds are some of private equity's most important investors. This unfortunately means that workers' retirement money can end up funding investments that hurt patients and workers.[73] You can work with your union to ensure current and retired

*If you want to learn more about organizing a union at your workplace, please reach out to the AFT at formaftunion@aft.org.

union members' pensions aren't being used to fund destructive businesses in healthcare or the larger economy. You can also advocate for your pension fund to take on the larger fight of changing private equity's practices. As AFT President Randi Weingarten and North America's Building Trades Unions President Sean McGarvey wrote, "Our members' retirement funds have over $4 trillion invested.... We agree with the [Biden-Harris] administration that private equity needs greater transparency, fairer fees, and a business model that grows strong businesses and creates good jobs—not one that exploits workers, loads companies with debt, and sells them off for parts."[74]

You can also learn about proposed legislation at the state and federal levels that will impact you and your patients. Your union can be a resource here and may be already lobbying for you and your coworkers. Learn how you can help with these policy efforts, such as by submitting testimony, showing up to rallies, or meeting with politicians.

Fight for Robust and Effective Policy

One of the reasons it has been so challenging for regulators and workers to hold private equity accountable for looting hospitals is that most of the tactics fall under the realm of legal business practices. If we want to stop the pillaging in the first place, we need to win legislation that removes incentives to loot hospitals or goes even further by making looting tactics illegal.

Much of the regulation of hospital sales and mergers happens at the state level. The good news is that many states have been beefing up their regulations in this area, often in response to how private equity has impacted healthcare in their regions. Since 2023, Illinois,[75] Minnesota,[76] New York,[77] Oregon,[78] and Washington[79] have passed legislation that increases state oversight of healthcare transactions; other states, like California,[80] are attempting to update their regulations. While these new state laws vary considerably,[81] they indicate an appetite among state legislators to better monitor healthcare transactions, especially those involving private equity.

Many of these laws primarily focus on increasing transparency and addressing anticompetitive effects of healthcare transactions, but they can and should go further to address the long-term financial viability of health systems, access to care, and quality of care. Rhode Island's Hospital Conversion Act addresses all of these issues and is perhaps the most robust piece of state legislation for overseeing healthcare changes of ownership.[82] It can serve as a starting place for other states considering new or updated legislation. In 2021, Rhode Island used this law to require Leonard Green & Partners to pay $80 million to an escrow account to help ensure its Prospect hospitals would stay open after Leonard Green's exit.[83]

State laws, and federal laws where applicable, should also address private equity's pillaging tactics by restricting or banning health systems from paying out debt-funded dividends to investors and barring investors from charging arbitrary fees to healthcare companies, such as management fees for services that haven't been provided.

One of the biggest loopholes in state laws regulating hospitals is that the laws typically pertain only to hospital operations, not to real estate. As we've seen with Steward Health Care, Prospect Medical Holdings, and other systems whose real estate has been stripped away in sale-leaseback transactions, monthly lease payments can burden hospital finances, cutting into operations in ways that impact patients and workers. Hospital real estate sales need to be regulated. Ideally, such transactions would be banned. At a minimum, health systems should be required to notify state and/or federal regulators of real estate splits and to provide essential information to and receive approval from regulators for sale-leasebacks. If sale-leasebacks are approved, there should be limits on using proceeds to line investors' pockets.

At the federal level, lawmakers should create joint liability for private equity firms and their portfolio companies. This would mean that private equity firms would also be responsible for the debt they load onto their portfolio companies, as well as be liable for any harms and illegal business practices, including Medicare and Medicaid fraud, that occur under their ownership. And importantly, lawmakers should close what is known as the carried interest loophole. This loophole has made it so that some portions of private equity firms' profits are taxed at a substantially lower rate than the average worker's income is taxed.[84]

Most importantly, we need strong enforcement of regulations at both the federal and state levels. In the absence of enforcement, laws and regulations are useless no matter how well designed they are. We need to fight for legislators and budgets that adequately fund the relevant state and federal agencies tasked with enforcing the laws that regulate for-profit healthcare.

Summing It All Up

The cracks within our broken for-profit health system offer greedy investors plenty of opportunities for plunder. Private equity's pillaging of hospitals is just one of the latest iterations of profiteering at the expense of patients, workers, and our collective well-being. But despite their immense wealth and power, private equity firms and the hospital landlords with whom they partner are not invincible. By organizing and winning effective policies, workers can use their collective power to hold these pillagers accountable and put a stop to the looting. ✚

For the endnotes, see aft.org/hc/fall2024/bugbee.

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Coalition Power

How Healthcare Workers and Communities Are Fighting Hospital Downsizing

By **Lois Uttley**

Lois Uttley, MPP, is a health policy and advocacy consultant and educator with 30 years of experience working with advocates and policymakers to protect community access to healthcare. She was formerly the director of the hospital MergerWatch Project and creator of the Hospital Equity and Accountability Project at Community Catalyst. She teaches in the graduate health advocacy program at Sarah Lawrence College.

Ashley Saupp and her husband, Sean Collins, were shocked when they learned in June 2023 of the planned closure of the nearby Burdett Birth Center where their three-month-old son, Ben, had been born. Burdett, located within Samaritan Hospital in Troy, New York, was targeted for closure by its parent health system, St. Peter's Health Partners (SPHP), because of reported financial losses and staffing issues. System executives said pregnant people could travel to the system's hub hospital in a neighboring county, or to other hospitals in the Capital District (which includes Troy and Albany).

"I was just outraged and astounded that a place where I had experienced such a joyful birth would be closed," recalled Saupp, who works for the Albany Social Justice Center. In an interview, she explained that "It would leave all of Rensselaer County without any maternity service at all and pose a real hardship for so many pregnant people who depend on having this center here and can't easily travel elsewhere. It would also eliminate the only midwife-led maternity service in our area, one that has the lowest C-section rate of any area hospital."[1]

More than half the patients Burdett serves rely on Medicaid, in a city with a poverty rate that is double the surrounding county and national levels (23.3 percent for Troy, compared to 11.2 percent for Rensselaer County and 11.5 percent for the nation). Troy also has higher percentages of residents who are Black and/or Latinx, speak languages other than English at home, or have disabilities—all groups that already tend to face barriers to accessing care; in addition, 22 percent of Troy residents don't own private vehicles, leaving them to rely on bus service. While Burdett is a short bus ride from downtown Troy, the nearest alternative maternity service in Albany requires two bus rides and an hour's travel, and the buses don't run overnight. Burdett also serves residents of far-flung rural areas of Rensselaer County, as well as adjacent and largely rural Columbia and Washington Counties, neither of which has a maternity service. Public transportation from those areas to Albany is nonexistent, and most are not served by ride-sharing services.[2]

Word spread quickly in the community; local families, midwives, and doulas, as well as community organizations such as the local YWCA, joined with Saupp and Collins to start the Save Burdett Birth Center Coalition (SBBCC). They began to turn out hundreds of concerned neighbors and healthcare workers at rallies and community meetings, posted Save Burdett lawn signs throughout the county, and took over billboards along local roads.[3] Collins, who is the president of the Troy Area Labor Council and a union organizer, mobilized support from unionized workers at other area hospital maternity wards to testify that their hospitals could

ILLUSTRATIONS BY STEPHANIE DALTON COWAN; PHOTOS COURTESY OF ASSEMBLYMEMBER JOHN T. MCDONALD III, NEW YORK STATE SENATE, AND AFT

not absorb the 800-plus births a year that would be displaced from Burdett. (Burdett and Samaritan workers are not unionized and were afraid to speak out.) The president of the Troy Firefighters Union testified that the city's emergency medical service was already stretched thin and could not take on transporting people with pregnancy emergencies to other counties.[4] A first-in-the-nation health equity impact assessment required under a new state law and a community-led version of the assessment both revealed serious consequences for medically underserved people that could not be easily mitigated.[5]

Eleven months later, SBBCC won its campaign. In April of 2024, SPHP executives withdrew their closure plan and accepted a $5 million state grant to help secure the future of the maternity service for at least five years.[6] The coalition's victory is one model of how healthcare workers and community residents are banding together with public officials to fight a tsunami of hospital downsizing and closures across the nation, and sometimes succeeding.

This article will examine the causes and consequences of recent hospital closings, downsizings, and sales across the nation and describe some of the community, union, and government actions being taken to protect patients and hospital staff. It will draw on the work of the SBBCC and efforts in other communities in highlighting important steps that can be taken to fight closures.

Where and Why Is This Happening?

The current wave of hospital downsizing and closing comes after more than two decades of consolidation in the health industry. Events of the last four years—disruptions caused by the COVID-19 pandemic, worsening staffing challenges, and serious deficits that some hospitals reported in 2022 and 2023—are prompting drastic actions. For example:

- In Lower Manhattan, residents who had depended on Beth Israel Medical Center for decades were horrified when its parent Mount Sinai Health System announced in late 2023 that Beth Israel would close after more than 100 years because of financial losses.[7]
- In central Brooklyn, the announcement in January of 2024 of the planned closure of financially troubled SUNY Downstate Medical Center* provoked outrage among the medically underserved residents who utilize the hospital and among the workers who care for them.[8]
- In eight states, patients and staff of 30 hospitals acquired by the for-profit health system Steward Health Care† watched nervously in the spring of 2024 as the system filed for bankruptcy. It already had shut hospitals in Massachusetts and Texas.[9] In June, a bankruptcy court judge allowed Steward to keep running the hospitals while seeking buyers for them, after Steward received an emergency loan.[10]
- In California, residents across large swaths of the state have limited access to obstetrics services, as 29 hospitals stopped delivering babies over the last three years and another four maternity wards were slated for closure in early 2024.[11]

Particularly affected are rural hospitals—nearly 200 have been closed or converted to other uses since 2005[12]—and urban hospitals serving primarily low-income neighborhoods. Patients are scrambling to navigate changed and unfamiliar health delivery systems, while hospital staff are forced to accept new positions at facilities farther away from home, with less seniority and less desirable hours.

Meanwhile, systems that acquired many hospitals over the last two decades are offloading some to buyers, including private equity firms. And the promises that health system executives made as they acquired hundreds of community hospitals are now being broken. In short, we are witnessing the other shoe dropping.

Promises, Promises: Two Decades of Hospital Consolidation

Over the last 20-plus years, there have been more than 1,800 hospital mergers and acquisitions through which hundreds of community hospitals joined health systems that have been growing bigger and bigger.[13] American Hospital Association data show that more than two-thirds of all hospitals in the nation are now part of a health system.[14] That wave of consolidation also reduced the number of hospitals from 8,000 to just over 6,000.[15] Overall, these trends have meant that the era of the independent community hospital is fast coming to an end.

Consolidation-related closures frequently impose barriers to care for vulnerable patients.

Of the nation's 10 largest health systems, the current leaders are the for-profit HCA Healthcare, which operates 184 hospitals, and the Veterans Health Administration, with 172 hospitals. Another four of the top 10 are for-profit systems: Lifepoint Health, with 124 hospitals; ScionHealth, with 94 hospitals; Community Health Systems, with 71 hospitals; and Tenet Healthcare, with 61 hospitals. Three systems are operated by Catholic-affiliated organizations: CommonSpirit Health and Ascension, each with 140 hospitals; and Trinity Health, with 101 hospitals. The remaining top-10 system, Advocate Health, has 61 hospitals and is a nonprofit combination of two smaller systems.[16]

In my more than 25 years of working with community coalitions across the nation and grappling with more than 135 proposed hospital mergers, I have observed executives of these systems make promises

*To learn more about the role AFT affiliates played in the successful fight to save SUNY Downstate, see "Fighting for Healthcare Access in Central Brooklyn" in the Spring 2024 issue of *AFT Health Care*: aft.org/hc/spring2024/kowal_kube.

†For a detailed review of Steward Health Care's troubles, and the broader impact of private equity on healthcare, see "How Private Equity Has Looted Our Hospitals" on page 18.

both to the hospitals they were acquiring and to the communities that depended on these local hospitals. Among the most frequent was the promise that the merger or acquisition would provide financial stability to ensure the hospital's future. Joining a big system, local hospital boards were told, would help with acquisition of electronic medical systems and negotiations on complicated value-based contracts. System executives also pledged better access to needed capital to renovate aging facilities.

For example, when New York's Mount Sinai Health System sought and received state approval in early 2020 to replace the aging Beth Israel Medical Center it had acquired in 2013 with a smaller but up-to-date facility nearby, executives proclaimed, "The new MSBI facility will be a full-service hospital consisting of inpatient beds, an adult and pediatric ED, radiology functions, operating rooms (OR) and IR suites, including neuro-IR and cardiac catheterization. The new hospital building will serve as a neighborhood hub of critical care, treating patients in need for life-saving treatment when suffering strokes, heart attacks, aneurysms and trauma."[17] That facility was never built. Instead, Mount Sinai announced its planned closure of Beth Israel three years later, citing financial losses.[18]

What "Quality Improvements" Mean for Patients and the Community

The main beneficiaries of consolidation are the health systems and their top executives.

Quality improvements have been another big selling point, with systems claiming their centers of excellence could improve quality at facilities throughout the system. But those better health outcomes often have failed to materialize, according to a recent summary of relevant research.[19] Instead, consolidation-related closures and rerouting of care frequently impose additional barriers to access for already vulnerable patients. And reorganization of health system service delivery patterns have often meant that patients must travel farther from home to unfamiliar hospitals and physicians.

Many of Beth Israel's patients are elderly and/or disabled and have low incomes. The largest proportion of patients come from two zip codes in the Lower East Side and East Village; in one, a quarter of the residents have incomes below the poverty level. More than half speak a language other than English at home, and 48 percent have only a high school education or less.[20]

As the Mount Sinai Health System moved to rapidly close services at Beth Israel in late 2023 and early 2024, even without closure approval from the New York State Department of Health, patients with serious conditions were rerouted away from the hospital's emergency department and sent to other hospitals in the system, located far uptown. One patient with a ruptured appendix who was experiencing sepsis had to wait an hour for an ambulance to another hospital.[21] Another Lower Manhattan resident who sought care after suffering broken ribs and a collapsed lung in a fall at home was initially treated at the emergency department, but then was transferred to a Mount Sinai hospital nearly 100 blocks uptown because of inadequate staffing at Beth Israel, according to an affidavit filed in a lawsuit over the proposed hospital closing. At that transfer hospital, he received little treatment and was sent home with no follow-up nursing care ordered. He ended up at Bellevue Hospital, where staff found that blood had accumulated in his lungs and abdomen, and he eventually died, according to the affidavit filed by his wife. "It is my belief that my husband's two weeks of suffering and his death would not have happened had Beth Israel Hospital been in full service," she said.[22]

Who Benefits from Greater Efficiency?

When advocating for mergers and consolidations, executives often make promises of improved efficiency and subtle suggestions that shared administrative costs and other measures would lead to lower prices. Mergers can decrease costs at the acquired hospital by 4 to 7 percent, one study has found.[23] Consolidation of certain services at a system's "hub" hospital (often an academic medical center) can reduce duplication of services across member hospitals and can help bring down the system's operating costs. But those efficiencies do not necessarily lead to lower prices for patients or for payers (and the hubs almost always mean patients having to travel farther).[24]

In fact, numerous studies have documented price increases associated with hospital consolidation, especially in places where a single hospital system gained control of more than half of the healthcare provider market, thereby reducing competition.[25] In addition to acquiring hospitals, these large systems have been increasing their market share and bargaining power by practicing *vertical integration*—acquiring or opening local urgent care centers and physician practices that are affiliated with (and sources of referrals or transfers to) system hospitals, as well as ambulatory surgery centers where many procedures once done in hospitals have migrated.[26] Three-quarters of hospitals and more than half of physicians are now affiliated with one of 635 health systems.[27]

The main beneficiaries of all these mergers and acquisitions turned out to be the systems themselves and their top executives. By growing larger, the systems gained greater market share and increased their bargaining power with health insurance companies, which have also been consolidating.[28] And as the systems have grown, so has their top executives' compensation, especially as the systems rebound from pandemic woes. For example, Sam Hazen, CEO of HCA Healthcare, the nation's largest system, saw his overall compensation grow to $21.3 million in 2023.[29]

Broken Promises, Shuttered Services

Over the last few years, the same systems that had rapidly acquired community hospitals began to downsize,

shut, or sell them. When systems are looking to improve the bottom line, maternity care is often the first service to be closed because, as healthcare analytics firm Kaufman Hall reports, "obstetrics and delivery services are one of the leading money losers of all hospital offerings."[30] One cause of these losses is low Medicaid reimbursement rates for labor and delivery.[31]

Two of the largest Catholic health systems, Ascension and Trinity, have been under fire this year for proposed or completed closures of maternity services at hospitals they acquired. Ascension has closed more than a quarter of the maternity units it had in 2012, shutting them at a faster rate than the national average. Many of the closings were in areas where people of color and people with low incomes depend on the local hospital.[32] And two recent cases involving Trinity illustrate how the system's promises to community residents have been broken.

Johnson Memorial Hospital in Stafford, Connecticut, was in serious financial difficulty when it joined the Trinity Health system in 2016. Executives promised the move would help bolster the hospital, which had twice filed for bankruptcy. Hospital President and CEO Stuart E. Rosenberg said, "This alliance preserves a critical community asset, allowing us to continue providing healthcare to the community, as well as serving as a significant contributor to the local economy. As part of Trinity Health–New England, our employees and patients can be assured of continued access to the hospital's 103-year legacy of providing uninterrupted health care services."[33]

However, labor and delivery services were closed during the first year of the pandemic, with temporary state permission; when that permission expired, Trinity Health–New England refused to reopen it.[34] AFT Connecticut Vice President John Brady spoke out in opposition to the closure: "While we recognize that continuing labor and delivery at Johnson Memorial Hospital may not be profitable, it must be balanced against the needs of the residents of the area, and Johnson Memorial Hospital should understand that it has a responsibility to provide basic healthcare services in the area." Trinity was fined $394,000 by the state of Connecticut for refusing to reopen the labor and delivery service and is appealing that fine.[35]

The Fight for Burdett

Trinity is also the national parent system of the health system that tried to close the Burdett Birth Center at Samaritan Hospital in Troy—St. Peter's Health Partners. SPHP gained control of Samaritan Hospital and nearby St. Mary's Hospital through a 2011 merger. It then merged the two hospitals' maternity services into a separately incorporated facility (Burdett), created on the second floor of Samaritan Hospital to avoid having maternity care come under the Catholic religious restrictions imposed throughout the rest of the previously secular Samaritan Hospital. Hospital executives promised that this maneuver would protect the continued provision of postpartum tubal ligations and contraceptive counseling, which are not permitted in Catholic hospitals.[36]

That promise was broken in 2020, when SPHP said financial challenges and loss of obstetricians necessitated the closing of the separately incorporated center and reabsorption of its maternity services into Samaritan Hospital.[37] Although advocates were dismayed at the loss of services not allowed under Catholic restrictions, they were reassured by the system's promise that the move would preserve the provision of maternity care in Rensselaer County.

But in June of 2023, SPHP executives broke that promise, too, and announced that Burdett would have to close. This was the last remaining maternity service in Rensselaer County, also serving pregnant patients from adjoining largely rural counties. SPHP said the birth center was losing $2.7 million a year.[38]

When healthcare systems look to cut costs, maternity care is often the first service to be shut down.

Burdett is a great example of the ways that patients and healthcare workers have been fighting back against plans to close or downsize local hospitals, and sometimes succeeding—at least in the short term. They have taken their concerns to local, state, and federal officials, looking for new policy approaches and funding to protect access to care in communities threatened by hospital closures.

In New York state, I and other healthcare advocates cheered the arrival of a new health equity impact assessment requirement we had fought for, which went into effect in June of 2023—just in time to help save Burdett.[39] It requires a hospital to commission an independent assessment of how medically underserved people—a category that includes people with disabilities, women, LGBTQIA+ people, immigrants, people who have public insurance or are uninsured, older adults, and rural residents—would be affected by proposed hospital changes, especially reductions or eliminations of services. It also requires a mitigation plan to address identified negative effects. The law amended the state's existing Certificate of Need process.

Burdett was the subject of the first such assessment, and the first potential test of the new law.[40] SPHP initially tried to evade the assessment requirement by filing the Certificate of Need application to close the center two days before the law took effect. But SPHP then agreed to the assessment voluntarily after intense public criticism. Concerned that this first-ever assessment commissioned by the system might be inadequate, SBBCC accepted my offer to help them conduct their own community-led assessment, which it sent to the state Department of Health

and posted on the coalition's website.[41] The coalition's assessment included conducting a community survey, interviewing people who had given birth at Burdett, studying the demographics of the affected community, examining the lack of affordable 24/7 options for transportation to other area hospitals, and hosting a community forum attended by more than 200 people. The written assessment concluded,

> Closure of the Burdett Birth Center would worsen health inequities, causing much harm to medically underserved people in Rensselaer County and adjacent communities. The closure would compound an existing maternal health equity crisis by eliminating a birthing site where pregnant women of color, LGBTQIA+ birthing people, and low-income people say they feel safe, listened to, respected, and not coerced into unneeded medical interventions.[42]

"Birthing safely shouldn't be a middle- or rich-class privilege. It should be for all."

–Jordyn Smith

Also included were quotes from people interviewed about their birthing experiences at Burdett. For example, Jordyn Smith of Troy said,

> As an African American woman, I have been failed countless times by the healthcare system. I have anxiety and fear when it comes to hospitals. My number one goal was to be heard and to bring my baby safely into the world. I had an amazing natural water birth at the Burdett Center in 2020. This community needs this center and its healthcare workers. Birthing safely shouldn't be a middle- or rich-class privilege. It should be for all.[43]

The assessment commissioned by the health system, while much less comprehensive than the community coalition's, also found significant negative effects and prompted delay of the center's closing by at least six months while the hospital and its parent system attempt to address those impacts.[44]

State Health Commissioner James McDonald issued a cease-and-desist order directing the health system to stop trying to shut down Burdett without his written approval of its closure plan.[45] State Attorney General Letitia James also stepped in, holding a public hearing in Troy[46] and ordering her Charities Bureau to investigate whether the nonprofit system was appropriately stewarding its charitable assets. The local newspaper, the *Times Union*, editorialized against the closure,[47] and the local Catholic bishop denounced it.[48] A bipartisan group of local and state public officials jointly testified against the closure at a community forum SPHP executives were forced to hold in February 2024 under state closure guidelines.[49]

The local state Assemblymember John T. McDonald III (brother of the state health commissioner) led efforts by public officials to save the birth center. He secured a five-year, $5 million grant for the Burdett Birth Center in the state budget that was approved in April of 2024. Faced with intense community opposition, the escalating attorney general investigation, and no action on their closure plan by the state health commissioner, SPHP officials opted to accept the grant and withdraw their closure plan.[50]

Although the state attorney general's office dropped its investigation into the proposed Burdett closing, it continues to investigate the financial relationships between Samaritan Hospital and both SPHP and its national parent, Trinity Health, including why Samaritan sent $98 million in unexplained "equity payments" to the Trinity Health system and its affiliates between June 30, 2019, and June 30, 2022. An affidavit filed in late July questions whether SPHP and Trinity are exercising undue control over Samaritan Hospital that is inconsistent with Samaritan's charitable mission, which includes providing hospital care to indigent people in Rensselaer County. SPHP and Trinity have filed a lawsuit seeking to quash the investigation.[51]

Fighting to Save Hospitals and Services—Together

New York's new state budget also contained funds to stave off the proposed closure of SUNY Downstate in Brooklyn. Members of United University Professions (UUP), an affiliate of the AFT representing state workers, worked with state legislators to fight an effort by the governor and the state university system to close SUNY Downstate. The budget appropriated $300 million in capital funds and $100 million for operating expenses to keep the facility running while an advisory board develops plans to evaluate the hospital's future.[52] But the budget did not directly provide any funds to save Beth Israel Medical Center, although there is a pot of money available for health facility "transformations."

Neither the proposed closing of SUNY Downstate nor the plan to shut Beth Israel Medical Center required a health equity impact assessment. Closures of entire hospitals, as opposed to elimination of maternity wards or other services, are carried out through submission of a formal notice and a closure plan to the state department of health, not a Certificate of Need application subject to a health equity assessment. Advocates and healthcare worker unions are supporting a new piece of legislation (S8843A/A1633B[53]) to remove that exemption and strengthen community engagement and state review of proposed hospital closures. An amended version of the bill passed both houses of the state legislature in June; as of early September (when this article was finalized for publication), it had not yet been sent to Governor Kathy Hochul for her consideration.[54]

Following the model of the SBBCC, the Community Coalition to Save Beth Israel conducted its own health equity impact assessment. The coalition circulated a community survey to which nearly 1,000 Lower Manhattan residents responded, conducted

in-depth interviews with some of those respondents, reviewed demographics for key Lower Manhattan zip codes served by Beth Israel, and assessed capacity at the nearest alternative hospitals. The coalition's assessment, *Lower Manhattan Lifeline: What Beth Israel Medical Center Means to Local Residents*, was sent to the state health commissioner and released to the public at a January 2024 press conference with state legislators representing the affected areas.[55] Key findings of the community's study included:

> Hundreds of low-income people, frail elderly, and people with disabilities—many of whom have relied on Beth Israel for their entire lives—report they are worried about losing the closest hospital they can turn to for care, especially in emergencies. They are unsure where else they could go, how to get there, or whether their insurance would be accepted. Those who have visited two of the potential alternative hospitals—Bellevue and NYU Langone—report long waits in the emergency department, even without the closure of Beth Israel.
>
> While lower Manhattan has its share of well-off people, the top two zip codes from which Beth Israel patients originate (10002 and 10009) have some of the city's poorest residents and high percentages of people of color. In zip code 10002, the median household income is only $46,000, and a quarter of the residents live in poverty.[56]

The state Department of Health (DOH) issued a cease-and-desist order to the Mount Sinai Health System over its continuing efforts to close Beth Israel Medical Center without written approval of its closure plan.[57] The department cited the hospital for repeatedly violating that order and then sent back its closure plan as "incomplete."[58] Meanwhile, volunteer lawyers from the Community Coalition to Save Beth Israel sued Mount Sinai and won a temporary restraining order against continued closure efforts that also required the system's "best efforts" to restore services it had already closed.[59]

In late May, Mount Sinai submitted an updated closure plan for Beth Israel to the state DOH. It included promises to create an urgent care center on the campus of neighboring New York Eye and Ear Infirmary that would be open seven days a week and to provide an unspecified amount of support to expand Bellevue Hospital's emergency department to accommodate some of the patients who would be displaced if Beth Israel closed.[60] In late July, the DOH granted conditional approval to the closure plan, although the temporary restraining order against the closure remained in effect because of ongoing lawsuits.[61] This action came days after Mount Sinai claimed staffing shortages were making it unsafe to continue to operate the facility,[62] and the same week that a news outlet revealed Mount Sinai had spent $72,000 on lobbyists in a final push to get approval for closing the hospital.[63]

In neighboring Connecticut, the State Office of Health Strategy has been aggressive in its review and, in some cases, rejection of proposed hospital downsizing, including planned closures of maternity units. Last year, it rejected Nuvance Health's plan to close the maternity unit of Sharon Hospital, located in a rural corner of the state—a decision Nuvance is appealing.[64]

Other states that have strengthened review of health provider consolidation include Oregon, where a new law gives the Oregon Health Authority (OHA) jurisdiction over proposed health industry mergers, acquisitions, and affiliations. OHA can reject such transactions if they would not increase access to services in medically underserved areas, improve health outcomes, or reduce patient costs. And in Minnesota, a new statute allows the state attorney general to seek court action barring or unwinding a transaction if it will "reduce delivery of health care to disadvantaged, uninsured, underinsured, and underserved populations and to populations enrolled in public health care programs."[65]

Efforts to address hospital closures and downsizing at the national level have also focused on the need for higher Medicaid payment rates, increased reimbursements for specific undervalued services such as labor and delivery, and special funding to preserve rural hospitals and urban safety net facilities. A 2021 congressional action created a new "Rural Emergency Hospital" designation that offered financial incentives to keep rural hospitals open, but also allowed them to cut most inpatient services.[66] Advocates, union representatives, and hospital officials have all been trying to persuade recalcitrant states to expand their Medicaid programs, with funding provided under the Affordable Care Act, to help support financially ailing rural hospitals. They cite the experience of Montana, which expanded Medicaid and has not seen its rural hospitals closing.[67]

Communities, healthcare workers, and officials need to work together to preserve access to hospital care.

Some hospital finances are improving in 2024 as patients begin to seek care they delayed during the pandemic.[68] But hospital downsizings and closings have continued as hospitals struggle with inflation, increased labor and pharmaceutical costs, frequent coverage denials from Medicare Advantage plans, and other problems. Communities, healthcare workers, and sympathetic local, state, and federal officials will need to work together to preserve essential access to hospital care across the nation. ✚

For the endnotes, see aft.org/hc/fall2024/uttley.

From "Do No Harm" *to* "Do More Good"

How Diversifying the Healthcare Workforce Benefits All of Us

By **Kimá Joy Taylor**

Kimá Joy Taylor, MD, MPH, is the founder of Anka Consulting, a healthcare consulting firm, and a nonresident fellow at the Urban Institute. Previously, she was the director of the Open Society Foundations' National Drug Addiction Treatment and Harm Reduction Program, a deputy commissioner for the Baltimore City Health Department, a health and social policy legislative assistant for Senator Paul Sarbanes, and a pediatrician at a federally qualified health center in Washington, DC.

My medical school experience was long and hard. It wasn't just the academic rigor or the fierce competition among my peers that is typical of medical school. I expected those challenges, and I was prepared to meet them. What made those years especially hard was constantly having to justify my presence in spaces where very few others—my peers, instructors, or other healthcare professionals—looked like me.

In the early days of my three-month surgical rotation, my chief resident (witnessed by other surgeons and scrub nurses) told me I wasn't intelligent enough to be there—that I was the product of affirmative action. "You're only here because you're Black," my chief resident said. "Black people really shouldn't be in medical school."

Later in the rotation, we rounded on a patient, an older Black man who was being treated for diabetic ketoacidosis. My chief resident and two other residents discussed what to do about the patient's diabetic wounds. The wounds looked serious, but the patient was stable after receiving a full course of antibiotics. The residents proposed a leg amputation—not because it was medically necessary, but because they wanted the practice.

The patient had no family or advocate, and he was not coherent enough to make decisions about his own care. Nonetheless, some of the residents were ready to manipulate him into signing off on a life-altering and very painful procedure just so they could meet their surgery quota. Although I was well aware of our nation's history of medical exploitation of people of color[1] and the persistence of racism-based beliefs about Black patients (such as "Black people have a higher pain tolerance"),[2] I couldn't believe what I was hearing—or that no one else was objecting.

As the only Black person on the team, I went to the chief of surgery with my concerns. The patient's leg was spared. But any hope of establishing trust between me and my colleagues evaporated. I spent the rest of that rotation studying nonstop on very little sleep so that my chief resident was unable to fail me (which he'd threatened to do) or write a negative evaluation that could doom my career before it had even begun. It was exhausting. To be clear, incidents like this were not limited to my surgical rotation—they occurred throughout my didactic and practical medical training.

By the time I was finally a practicing pediatrician, I had witnessed dozens more patient encounters marked by racial, ethnic, or cultural insensitivity—in some cases, my own insensitivity. These encounters were a symptom of a larger problem: the persistent inequities in the United States that have resulted in few patients from historically underrepresented

ILLUSTRATIONS BY ELIZABETH MONTERO

groups sharing an identity with their clinicians and fewer people from these groups pursuing critical roles in the health professions.[3]

This has to change.

✚ ✚ ✚

The United States is facing a growing shortage of healthcare professionals.[4] As we seek to grow the workforce caring for our increasingly multiracial and multicultural society, it's crucial that we focus on diversification. Recruiting and retaining a healthcare workforce that reflects the racial and ethnic diversity of the communities they serve and holding the entire workforce to the goal of providing culturally and linguistically effective care is the only path to equitable outcomes for all.

The need for a more diverse healthcare workforce is well documented. Although Latinx, Black, and Indigenous peoples comprise 18.5, 13, and 2.5 percent of the US population, respectively, they are significantly underrepresented among physicians in the healthcare workforce (5.8, 5, and 0.4 percent, respectively).[5] According to the 2022 National Nursing Workforce Survey, most registered nurses are white (80 percent) despite white people being 58.4 percent of the population. Just 6.9 percent of registered nurses identified as Hispanic or Latinx, 6.3 percent as Black, and 0.4 percent as American Indian or Alaskan Native. The only racial group represented adequately was Asian American or Pacific Islander, at 7.5 percent (though our history of drawing on Filipino nurses makes this a pyrrhic victory*).[6]

National statistics often understate regional gaps in representation, but tools such as the Mullen Institute Health Workforce Diversity Tracker give a good picture of national and state-level data on workforce diversity.[7] As one would expect, representation varies by geography, but overall, people of color face underrepresentation in a range of healthcare professions. One exception is in health service occupations. A 2017 report showed that of 30 health occupations, people of color were only well represented, if not overrepresented, in health support, personal care, and other service roles—positions that do not require a college degree and typically pay less and provide fewer benefits than other healthcare roles, which is equally concerning.[8]

Concerted efforts on the part of some medical, nursing, and midwifery school institutions led to a slight enrollment increase for some historically underrepresented populations (American Indian or Alaska Natives and Hispanic or Latinx) in the 2023 matriculation year.[9] However, the Supreme Court's 2023 ruling on affirmative action policies for college admission—which deemed consideration of race or ethnicity unconstitutional—is likely to reverse this positive, albeit slow, development. There is precedent for this concern: several states that ended affirmative action programs in previous decades have seen higher education enrollment decline among historically underrepresented populations, and evidence suggests these declines are persistent.[10] In light of this, organizations such as the Association of American Medical Colleges are working to understand the consequences of the ruling and to maintain diversity efforts in medical schools and healthcare training programs.[11]

Given our nation's increasing diversity and the growing resistance to diversity, equity, and inclusion efforts,[12] it is more important than ever that we support and sustain diversity across all health professions. This article seeks to help readers understand why diversity is important for all healthcare teams and how unions can push healthcare systems to be part of the solution.

The Case for Representative Care Teams

A common condition that brings children and their families to seek healthcare is ringworm of the scalp. While there are multiple possible treatments, many clinicians typically prescribe an antifungal shampoo that must be applied to the scalp and rinsed out at least three times a week. The treatment sounds easy enough; for Black children and families, it's often anything but.

Some clinicians do not know that many Black people do not wash their hair this frequently. Black hair types have different needs than other hair types; additionally, some Black people straighten their hair or wear protective styles that do not hold up well with frequent washing. So while Black families may accept the shampoo prescription, many will only use it on their normal washing schedule—which is not often enough to be effective. At the follow-up visit, the child's scalp may be little improved or show worsening hair loss. In my experience, many clinicians in this situation have become frustrated, commented that such families are uncaring or lack parenting abilities, or made threats about noncompliance.

People of color face underrepresentation in a range of healthcare professions.

I have had to explain that Black children's hair dries out easily with too many washings, and that it is time consuming to wash and then comb out thick hair multiple times per week. My hope is that next time these clinicians will respond with cultural understanding and respect—and offer an oral antifungal that can clear up the infection much more quickly, perhaps in conjunction with the shampoo just once per week. The children would return with an improved scalp, and the clinician-patient relationship would be furthered. But I also have a broader hope: that these clinicians will approach the next family with an open mind. Even

*To learn about the outsized role nurses trained in the Philippines play in the US healthcare workforce, see "Investing in Our Future" in the Fall 2021 issue of *AFT Health Care*: aft.org/hc/fall2021/bailey_moon.

with deeper awareness, we can't predict everything that will impede compliance—but we can create spaces in which families feel welcome to share their questions and concerns, and in which we take the time to engage with and learn from them.

Examples like this illustrate why we need a more diverse healthcare workforce—and also a more representative one. Diverse healthcare teams include professionals from many different backgrounds and identities, including race, ethnicity, language, religion, socioeconomic status/class, ability, sexual orientation, and gender identity.* Representative teams go a step further, cultivating as much concordance as possible between the team and the community being cared for. To optimize patient outcomes and staff well-being, it's imperative to focus diversity efforts on groups with predictably worse outcomes and with less access to joining health professions.

In 2021, 63 percent of nurses—including 92 percent of Black nurses—reported experiencing a racist act in the workplace.

It's also crucial to note that diverse and representational healthcare teams can improve outcomes for *all* patients and well-being for *all* staff. This broader argument, often left out, is needed to sway those who may be leery of the effort involved in recruiting and supporting diverse staff. Diversification is not a zero-sum game: it is a process that supports us all. More specifically, a diverse healthcare workforce:

1. *Improves cultural understanding.* Increasing diversity among students entering health professional training programs creates space for more inclusive conversations that can lead to greater understanding of medical conditions and treatments.[13] And increasing the number of diverse health professionals in the workplace creates opportunities for clinicians to increase their cultural awareness by learning to recognize that patients have different life experiences.[14] They can then listen and ask meaningful questions when seeking to engage patients, collaborate with colleagues, and improve individual outcomes.[15]

2. *Enhances clinician-patient trust and patient outcomes.* Increasing representational diversity within health professions can improve patient satisfaction and outcomes—especially for patients of color.[16] Research has shown that racial concordance (i.e., when a patient and clinician share a racial identity) can lead to more trusting relationships, increased patient satisfaction, and often improved outcomes.[17] In two studies, for example, Black and Latinx men seen by physicians who shared their racial and/or cultural background† were more likely to adhere to treatment plans, engage in preventive services, and agree to care recommendations.[19]

   Other research suggests that language concordance (i.e., when a patient and clinician speak the same language) is associated with higher patient perceptions of healthcare quality and higher patient experience ratings.[20] Language concordance has also been shown to improve patients' health and safety outcomes.[21] For this reason, identifying, recruiting, and supporting bilingual health professionals is a necessary goal for all healthcare institutions. While there is a federal requirement to provide language services for those with limited English proficiency,[22] this does not always occur.

3. *Boosts health professionals' well-being.* The healthcare staffing crisis has critical implications for health professionals' well-being. Heavier workloads (including higher patient-to-clinician ratios) lead to increased exhaustion, burnout, and risk of moral injury‡ and decreased job satisfaction and mental well-being.[23] These outcomes may be attenuated and even prevented if an institution is willing to expand the candidate pool when recruiting employees in order to address the staffing shortage.[24]

   Racism and discrimination in the workplace cause additional harm to healthcare professionals who are already experiencing work-related stress, contributing to burnout and turnover. A 2021 national survey of more than 5,600 nurses revealed that 63 percent of all nurses—and 92 percent of Black nurses—had experienced a racist act in the workplace, and 75 percent had witnessed one.[25] A 2023 survey of 3,000 healthcare workers reported that most (and particularly those working in facilities serving majority-Black or majority-Latinx patients) had experienced stress related to discrimination.[26] Increasing diversity of the healthcare team can reduce the level of implicit biases and stereotyping, and it may lead to improved interactions[27] between colleagues as well as between clinicians and the patients and families they care for.

*While we often discuss identity categories separately, especially in research, people who hold those identities cannot separate out how they experience them. To learn more about how intersecting identities affect LGBTQ people of color in healthcare spaces, see "Improving Care of LGBTQ People of Color" in the Fall 2021 issue of *AFT Health Care*: go.aft.org/by0.

†I am not arguing for, nor do I believe in, racial concordance to the point of resegregation, where patients are only treated by clinicians with whom they share a racial identity. Not only is this unfeasible, as we are dispersed across the nation, but it is not equitable and denies the diverse and intersectional identities within patient populations. Consider, for example, that neither racial nor language concordance ensures culturally effective care (i.e., healthcare that respects a patient's cultural identity and heritage as well as the cultural factors that can affect health).[18] Even as health professions diversify, all clinicians will still have a responsibility to get to know their patients so as to offer the best possible care.

‡*AFT Health Care* has published several articles on moral injury documenting the challenges healthcare workers face and how to address them; see go.aft.org/78a.

4. *Increases patient access to care.* The US Health Resources and Services Administration has designated specific geographies, populations, and facilities as Healthcare Professional Shortage Areas due to their inability to recruit or retain primary care, dental, or mental health care clinicians.[28] Recruiting a diverse array of clinicians is likely to directly impact these shortage designations, improving clinician supply and increasing patients' access to care.[§] Research suggests that clinicians from historically underrepresented groups in a variety of specialties are more likely to work in shortage areas, accept Medicaid (which has a lower reimbursement rate than other insurers), see more patients from historically underrepresented groups, and spend more time with patients.[29]

5. *Strengthens recruiting and retention.* Expanding the pool of people from which an organization hires increases the number of applicants—and most applicants highly value organizational diversity. One employee study found that for more than 75 percent of job seekers, diversity is an important factor in evaluating potential employers.[30] Applicants who perceive an organization does not prioritize diversification efforts may be unwilling to join, leaving the remaining staff to face the negative patient and personal consequences of staffing shortages.

   Supporting diversification has also been cited as a way to improve retention of all staff. Results of an employee survey suggest healthcare systems that do not prioritize diversity lose twice as many employees as their more diverse counterparts[31]—leading to not only significant institutional costs to hire and train new staff but also worsening patient outcomes along with increased burden and risk of burnout, higher dissatisfaction and turnover, and decreased well-being for staff who remain.[32]

6. *Enriches team and organizational performance.* Healthcare team diversity has been shown to improve team communication and the accuracy of clinical decision making, in addition to improving patient outcomes.[33] Although research on productivity and performance related to healthcare workforce diversity is more recent and still fairly limited, studies focusing on organizations with parallels to healthcare show that diverse work environments foster greater productivity and performance for the entire team—and demonstrate financial benefits for the organization.[34] These studies also show that diversifying teams across an organization, including on the governing board, can lead to greater innovation, challenges to past thinking, and new ideas that can help improve performance (e.g., risk assessments, problem solving new workflows, and solutions to improve care or efficiencies).

[§]Of course, it is not possible to recruit clinicians who do not exist. The representational entry of students into healthcare training programs is also necessary to increase access to care in these shortage areas. While equalizing opportunities to learn from birth through higher education is outside the scope of this article, everyone concerned with equitable patient care should be advocating and voting for fully funding public schools and for family supports (like early childhood education) to give underrepresented youth opportunities to become health professionals.

While these benefits demonstrate that health professional diversity is sorely needed, it should not supplant student choice. Federal, state, and local policies often seek to "diversify" professions in ways that only serve their interests—such as diversifying lower-paying jobs without offering career pathways to higher-paying, more specialized positions. But students must have the freedom to choose the course of their profession particularly *because* diversity is needed (and lacking) across all types of health professions, including primary care, specialty care, nurse practitioners, phlebotomists, radiology technicians, community health clinicians, and more. We need, for example, diverse dermatologists who can diagnose melanoma across various skin colors and provide culturally and linguistically effective care just as much as we need diverse primary care physicians.

Additionally, the benefits of workforce diversity noted above require diverse representation within *all* levels of the workforce and an environment in which teams share power so that all voices are heard and all team members can share ideas and wisdom. Medicine is a hierarchical system; if only leadership voices count, and those voices are not representative of the larger community, having diverse members among the rest of the team will not have the same positive effects. Returning to the ringworm example, a Black certified nursing assistant could have explained the issue with the shampoo—but only if the higher-level clinicians created an environment in which speaking up was valued.

Diverse, representational healthcare teams can improve outcomes for *all* patients and well-being for *all* staff.

A Call for Cultural Humility

While diverse healthcare representation is crucial, diversification alone will not ensure more equitable outcomes. It is but one important piece of the solution. Another essential piece is ensuring that all health professionals learn how to provide and are accountable for providing culturally and linguistically effective care. This is impossible without developing what pediatrician and community activist Melanie Tervalon termed *cultural humility* (which entails learning to listen to and respect patients' expertise about the cultural contexts of their lives and health needs).[35] Cultural humility is often developed through experience—including from mistakes like one I made early in my career.

In my third year of pediatric residency, I worked in a hospital on a Native American reservation. On my third day, I saw a two-week-old patient with a high

We need diverse dermatologists who can diagnose melanoma across skin colors just as much as we need diverse primary care physicians.

fever. I didn't even have to think; my years of training kicked in. The baby needed an immediate workup to rule out sepsis (which is a fairly invasive procedure) and antibiotics.

The parents told me to wait; they first needed to speak to their medicine person and agree on a treatment plan. I pressured them; I even used scare tactics. I told them that there was no time to waste because sepsis in infants can lead to damage to the brain and other organs or even death. They needed to act immediately.

In distress about the infant's health and truly agitated that these parents did not seem to understand the urgency of the situation, I sought out my preceptor, an older white family practitioner who was the hospital's medical director. He listened to my problem and then asked a question: Had I tried to understand what this family wanted and why?

I hadn't.

My preceptor returned with me to the exam room to talk with the family. A short time later, they'd consulted with their medicine person, who was just 10 minutes away, and returned for the sepsis workup and antibiotics. (And the baby improved.)

I'll never forget what my preceptor told me afterward: "Yes, pediatrics is your expertise, and you were doing what you thought was best. But this is not about you. It's about patient-centered care. You have to stop talking and *listen*."

This experience taught me to put aside my agenda and prioritize cultivating rapport with patients and families based on deep respect for their culture, knowledge, and experiences. I also learned the value of colleague-to-colleague trust, support, and modeling of strategies that lead to greater cultural awareness and humility. Healthcare professionals aren't perfect and can't know everything. But in listening to patients and being accountable to each other to deliver culturally or linguistically effective care, we more completely fulfill our obligation to patients—not to "first, do no harm," but instead to "do more good."

The Way Forward: Diversifying the Health Professions

Despite the many challenges to improving representational diversity in the health professions, there are reasons to be optimistic. Several programs and practices designed to increase access to the health professions and decrease turnover have been successful, and we can learn from their work.

Building Health Professions Pathways

Pathway programs that support entry of young people from historically excluded populations into the health professions have been shown to help diversify the healthcare workforce. These historically excluded populations often face several barriers to entering health professions, including being redirected or discouraged from pursuing health careers due to discrimination, lack of knowledge of how to gain entry, lack of K–12 academic supports, and lack of money. Pathway programs offer the supports needed to reverse these and other barriers. A recent study[36] identified key components of these programs: academic enrichment, financial support, and social and institutional supports.

Academic enrichment. Many underrepresented populations attend schools that do not offer rigorous, advanced classes due to historical and ongoing segregation and inequitable distribution of resources. These students may require enrichment supports to help them gain entry to and succeed in health professional schools. Through components like make-up courses in the summer before college, internships, and academic advising and career supports, academic enrichment programs can help level the playing field as young people enter and seek to graduate from health professional training programs.

Financial support. Students from historically excluded groups who want to become doctors need an array of financial supports (including for living expenses) that are not conditional on choosing primary care or service in underserved communities so they are able to choose medicine over other shorter training programs. Postsecondary and postgraduate education are expensive, and many cannot afford the delayed financial gratification; additionally, many must focus on meeting current individual or family financial needs.

Social supports. Study participants repeatedly mentioned mentoring—beginning as early as middle school and continuing through professional degree attainment and into clinical practice—as essential to helping them navigate educational demands and professional development opportunities and deal with microaggressions and implicit bias. Noting the importance of exposure to various clinical disciplines, many participants expressed the need for mentors who could help them explore or enter other specialties if desired. In addition, study participants noted a need for mentoring in college and postgraduate education to support retention. Because of the lack of diversity within health professional leadership and teaching positions, historically excluded students often had difficulty finding a racially or ethnically concordant mentor who could guide them through discrimination, career discouragement, and other social barriers they faced.

Institutional supports. Institutional supports are those that not only facilitate entrance into pathway programs but also sustain the welcoming, inclusive environment necessary for successful graduation and equity in educational and work settings—such as institution-wide championing of diversity, equity, and inclusion practices and commitment

to continual development or refining of pathway interventions.

Supportive institutions hold individuals and systems accountable when students face racial discrimination or hostility. As noted earlier, a large percentage of nurses have witnessed or experienced racism on the job.[37] Unless institutions hold the perpetrators accountable, the hostile work environment will lead to decreased entry and retention of underrepresented students, increasing the workload of those who remain.

It is important to note that many pathway programs have and continue to face significant challenges that must be addressed to ensure their efforts are successful and sustainable. These include but are not limited to anti-affirmative action policies that limit pathway access, lack of access to sustainable funding, lack of institutional support, and lack of institutional recognition of the importance of retention efforts.

Increasing Retention Through Workforce Investments

Systems that strive to increase the entry of diverse workers into the health professions must consider how they will retain these workers. The strategies below focus on cultivating welcoming workplaces with supportive policies to ensure that both new hires and existing care team members feel valued and desire to remain in practice.

Develop effective policies to ensure a safe, hostility-free workplace. Workplace violence is an ongoing crisis affecting worker well-being and retention. Studies among nurses have shown that workplace violence increases burnout, stress, job dissatisfaction, and staff turnover[38]—and workplace violence increases with understaffing and when staff have high levels of stress.[39] Workers must know that their safety is important and will be protected. Organizations must develop, implement, and adhere to equitable policies to prevent workplace violence, and establish consequences when it occurs, including violence perpetrated by patients.[40] These policies must also ensure protections for staff who report safety issues, including those related to racism or discrimination. Healthcare professionals who have come forward have reported being dismissed, sidelined or forced out, and seen as not being a "good fit,"[41] which only contributes to an even more unsafe, hostile work environment.

Implement equitable workload, professional development, and financial supports. Healthcare professionals of color often receive less pay, are not compensated for higher workloads they carry because of participation in equity endeavors, and have a harder time receiving promotions and mentorship. To increase equity in this area, consider the following strategies:

1. *Compensate those who lead or support diversity and equity work.* Leaders and workers of color (particularly women of color) are often expected to inform or lead organizational efforts to increase diversity and equity in addition to their other commitments.[42] Compensating these individuals through funding, time, promotions, or other benefits and increasing the expectation that all staff engage in and lead diversity work can improve this dynamic.

2. *Provide qualified language services.* To provide linguistically effective care to patients with limited English proficiency, bilingual clinicians often have to carry their workload *and* support their nonbilingual colleagues without additional resources. They also may not have the necessary vocabulary to provide medically accurate interpretation.[43] Ensuring access to qualified interpreters can help alleviate the burden on these clinicians. However, it is important to have bilingual clinicians and recommend that others on the healthcare team learn a new language, even if at just a basic level to help build rapport with patients and their loved ones.[44]

3. *Provide equitable salaries and benefits.* Healthcare professionals' financial concerns also affect retention. Workers of color across the healthcare professions experience wage disparities[45] and are overrepresented in lower-paying fields and careers,[46] which limits their ability to repay educational loans, meet family needs, and accumulate wealth. Addressing this barrier requires equalizing pay across racial groups, increasing salaries and benefits in some historically lower-paying fields, and building career pathways that provide upskilling and increased access to all health professions.[47]

4. *Champion loan repayment and scholarship programs.* Educational loan repayment programs can help improve workforce representation along race, ethnicity, socioeconomic status, and other parameters; yet, it is a huge ask to expect students from historically excluded groups to take on large debt with only a possibility of loan repayment upon training completion. For this reason, scholarships may be more effective. It's worth noting again that such programs would be more beneficial if they did not have narrow parameters such as requiring primary care and/or working in underserved areas.[48]

5. *Increase transparency around promotion opportunities.* Healthcare professionals of color are significantly less likely to advance to senior leadership positions than their white counterparts. Thus, the American College of Healthcare Execu-

Diversification alone won't solve the problem—all health professionals need to provide culturally and linguistically effective care.

tives developed comprehensive recommendations for increasing and sustaining racial diversity that include greater transparency about promotion qualifications.[49] I would add that organizations should also expand their promotion criteria so that time spent on equity and community initiatives and other often ignored but critical endeavors count toward tenure alongside more traditional criteria like publication. If young people don't see a clear path for their entry, success, and retention in the health professions, they may be less willing to engage.

6. *Provide job shadowing and exploration experiences.* In a 2022 study, many nurses of color noted they only knew the pathway to nursing because a family member had been a nurse. They emphasized the need to highlight the existence of varied health professional careers and to explain entry requirements.[50] Through job shadowing and career exploration opportunities, young people from historically excluded groups can not only discover health professional careers that are available to them but also better understand the paths to entering and remaining in these professions.*

What Unions Can Do

Making meaningful progress in diversifying the healthcare workforce despite longstanding, purposeful, systemic barriers requires an all-hands-on-deck approach. It requires determination, understanding of historical efforts (both successful and less so), and expanded partnerships. Unions, with their varied healthcare members and community partners, can be a powerful and welcome voice for change.

Unions can be a powerful voice for diversifying the healthcare workforce.

Unions are an important part of the advocacy structure that can persuade policymakers, educational institutions, and employers to prioritize representational diversity in their communities and beyond. They can also use collective bargaining to support entry and retention of historically excluded groups in healthcare organizations. Below is a list of tools, policies, and processes that might be included in bargaining:

- Annual collection of employment data and surveys (conducted anonymously to prevent targeting) to understand the scope and experiences of diversity within the organization (e.g., Who is in the organization? How long have they worked here? How do they feel about diversity in the workplace? Have they experienced or witnessed biased remarks or actions? Are wages and benefits equitable across race, ethnicity, gender, and other variables that should not affect compensation?).
- Quarterly collection of data on workplace violence to understand when incidents occurred and how they were resolved, and to consider how they could have been prevented. Additionally, collection of workplace safety protections that are enforced.
- Implementation of the Institute for Healthcare Improvement's Joy in Work framework for decreasing staff burnout, moral injury, and turnover while increasing engagement and well-being.[51]
- Staff compensation (financial or time) for community-based mentoring activities intended to increase diverse youth knowledge of and entry into health professions.
- A fair appeals process and whistleblower protections for those who speak out against racism and discrimination within the organization, along with a yearly public report on complaints and how they were resolved.
- Ongoing supports and programs to help healthcare professionals pay for continuing education, upskill training, language courses, and other activities that can increase both workforce diversity and culturally and linguistically effective care. Importantly, programming for "all participants" must recognize that participants have differing barriers and levels of opportunity that may lead to inequitable treatment and outcomes in terms of hiring, promotion, retention, and physical and mental well-being.
- Adoption of transparent hiring, promotion, and retention practices that reward efforts to ensure a diverse and welcoming work environment for all employees.

Equitable patient outcomes should be a goal of all healthcare systems, practitioners, and policymakers. We cannot hope to do more good for our patients, families, and communities without diversifying the health professional workforce and providing the support and respect that students and practitioners need to enter and remain in their chosen professions. The fact that barriers created to sustain inequitable healthcare access and outcomes still challenge this work does not mean we should turn away from the goal; it simply means we should be honest about what is needed to achieve success. Though improved patient outcomes is a North Star driving healthcare diversification efforts, organizational leaders and staff of all identities accrue meaningful benefits that should encourage us to work together for lasting change. ✚

For the endnotes, see aft.org/hc/fall2024/taylor.

*To read about a high school in a hospital that introduces youth to the full range of healthcare careers, see "Creating a Healthy Community" in the Spring 2024 issue of *AFT Health Care*: aft.org/hc/spring2024/hummer.

Why Are We Not Already More Diverse?

Many healthcare stakeholders, including clinicians, medical and nursing education faculty, policymakers, advocates, and organizers, have long sought to increase the diversity of the health professions. Key advocates in these efforts have been individuals from systematically and structurally excluded groups—including Black, Indigenous, and other people of color; women; individuals who are transgender or nonbinary or who have disabilities; and individuals who live in poverty—who have been disenfranchised through our nation's history and faced barriers that have contributed to past and present inequities. Yet, despite decades of efforts, the US healthcare workforce still lacks representational diversity. Why?

Many conversations about our lack of diversity try to shift blame onto those who have been historically and systematically excluded in order to relieve organizations of the obligation to invest in hiring and building career pathways for diverse populations. But history demonstrates the purposeful exclusion of these populations as well as the development of systemic barriers that perpetuate lack of diversity. Slavery, the annihilation and forced assimilation of Indigenous peoples, and systemic and institutionalized racism have laid the groundwork for today's disproportionately homogeneous healthcare system that was built to exclude, harm, and create inequities.

Setting aside broader social barriers (such as historical and modern redlining[1] preventing Black families from building wealth and making higher education prohibitively expensive for many) and just focusing on healthcare-related barriers, there are a multitude of examples. Here are just a few:

- The history of trauma and exposure of Indigenous peoples to infectious and chronic diseases that contributed to persistent health disparities, unfulfilled commitments related to the provision of healthcare, and the lack of access to care or healthcare infrastructure beyond the critically underfunded and understaffed Indian Health Service.[2]
- The postslavery decimation of Black community healthcare models, including the closure of historically Black medical schools and displacement of Black midwives through the 1910 Flexner Report[3] on medical education and the Sheppard-Towner Act of 1921,[4] resulting in limited career opportunities for Black clinicians.[5]
- The racial segregation of many US hospitals that persists today[6] and the racial exclusivity laws and practices that prevented clinicians of color from attaining professional credentialing and certifications or working in segregated hospitals[7] while also excluding them from historically all-white trade and professional associations like the American Medical Association.[8]

The fact that many systemic barriers remain in place today to prevent entry of historically excluded groups into the health professions makes knowing our history more important. Only by knowing about these barriers can we remove them. Barrier work must occur across K–12 and higher education and also focus on hiring and retention efforts that help individuals from systematically and structurally excluded groups secure positions in the healthcare workforce upon school graduation. The various leverage points allow anyone interested in the end goal to find a place to start.

Resources for Further Learning

Deep dive into the history of health inequities in the United States

- "How History Has Shaped Racial and Ethnic Health Disparities" (go.aft.org/weh)
- "Healing Histories Project: Disrupting the Medical Industrial Complex" (go.aft.org/yyq)
- Urban Institute Symposium, "Unequal Treatment at 20: Accelerating Progress Toward Health Care Equity" (go.aft.org/9ip)

History of healthcare inequities for Indigenous peoples

- "A Historical Perspective of Healthcare Disparity and Infectious Disease in the Native American Population" (go.aft.org/ux3)
- "Discrimination Against Indigenous Peoples Through the Eyes of Health Care Professionals" (go.aft.org/xat)
- "Inadequate Healthcare for American Indians in the United States" (go.aft.org/fqy)

More on the impact of the Flexner Report and Sheppard-Towner Act

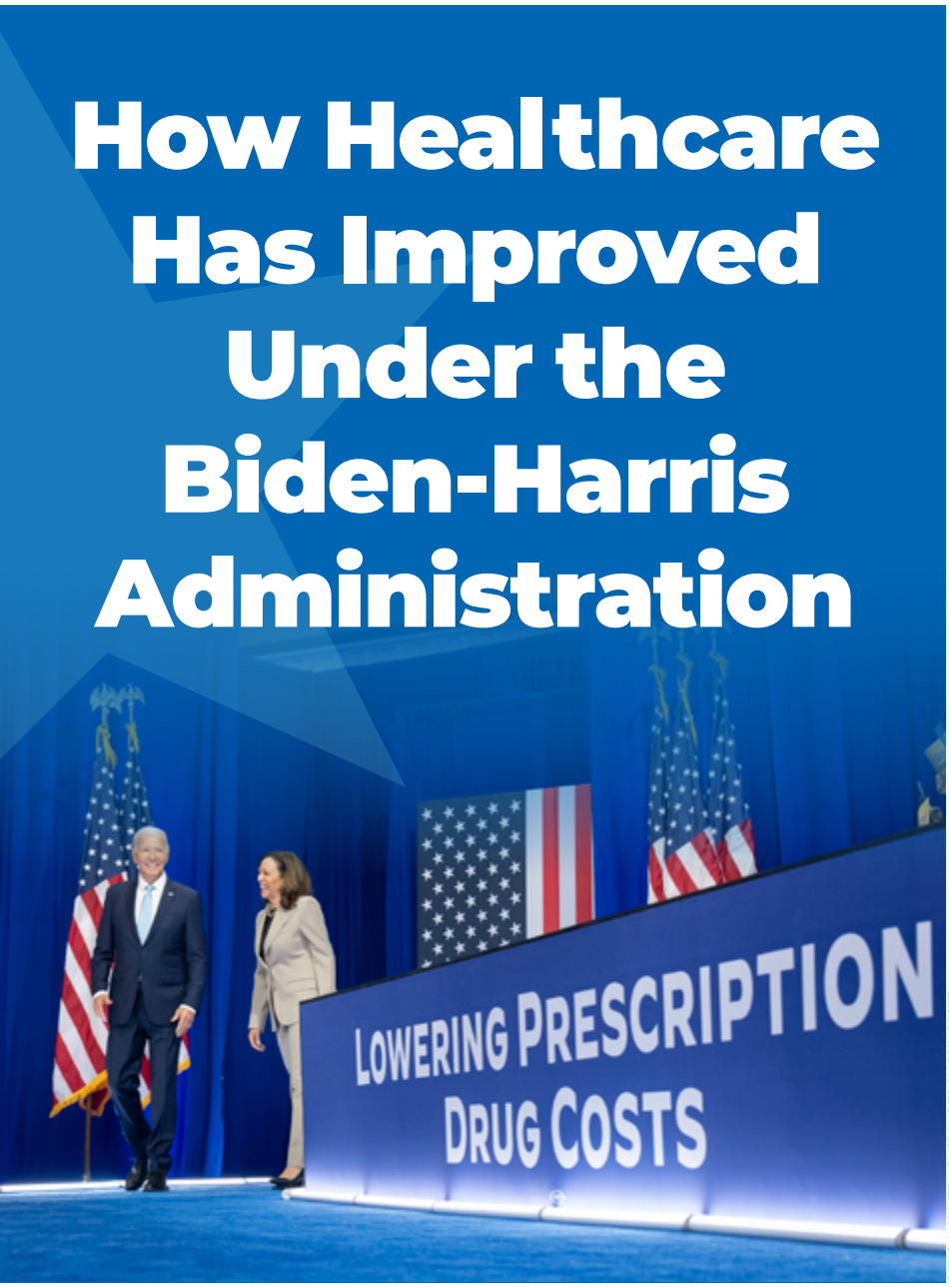
- "Racial Bias in Flexner Report Permeates Medical Education Today" (go.aft.org/9n5)
- "Constructing the Modern American Midwife: White Supremacy and White Feminism Collide" (go.aft.org/vlv)
- "The Midwife Problem: The Effect of the 1921 Sheppard-Towner Act on Black Midwives in Leon County" (go.aft.org/vhe)

Many systemic barriers still prevent entry of historically excluded groups into the health professions.

–K. J. T.

For the endnotes, see aft.org/hc/fall2024/taylor_sb.

How Healthcare Has Improved Under the Biden-Harris Administration



OFFICIAL WHITE HOUSE PHOTO BY ERIN SCOTT

By **Joi Chaney**, **Andrea Harris**, **Anne Shoup**, and **Maddie Twomey**

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In every election since 2018, voters have gone to the polls prioritizing better healthcare and lower healthcare costs.[1] Healthcare is a kitchen table issue, and policies to lower costs receive strong support from a majority of voters, whether they live in red or blue states or in rural, suburban, or urban zip codes.[2] This year, healthcare continues to dominate the national political conversation, as both presidential candidates have radically different visions for the future.

The state of US healthcare has improved substantially over the last four years. President Joe Biden, Vice President Kamala Harris, and Democrats in Congress have protected and strengthened the Affordable Care Act (ACA) and Medicaid, helping millions of families gain affordable coverage. Congress passed the Inflation Reduction Act,[3] a landmark law that is lowering prescription drug and premium costs for millions of seniors and families. The Biden-Harris administration has also worked to improve children's coverage, strengthen maternity care, and reduce racial, rural, and other disparities in health.

This year, a record 21.3 million Americans signed up for health insurance through ACA marketplaces—over nine million more than when President Biden took office.[4] Seniors are saving on their prescriptions, paying no more than $35 a month for insulin, and gaining access to free vaccines.[5] Starting in 2025, no one on Medicare will pay more than $2,000 for all their medications, a game-changer for people with serious conditions like cancer, arthritis, and heart disease.[6] And for the first time in history, Medicare is negotiating with drug companies for lower prices on some of the most expensive drugs on the market.[7] Together, these changes have increased financial security for families while making lifesaving healthcare more affordable.

From Crisis to Care

Four years ago, the US healthcare system was in crisis. The nation was in the throes of the COVID-19 pandemic, with healthcare workers fighting to save lives and economic uncertainty threatening families' well-being. Former President Donald Trump's response to the crisis undermined the health and safety of the American people and strained a healthcare system that his administration had already systematically compromised. During his time in office, Trump enacted policies that weakened protections for 135 million people with preexisting conditions,[8] made it harder to enroll in affordable coverage, and raised healthcare costs for millions of people.[9]

One of Trump's top goals while in office was to repeal the ACA, which roughly 27 million Americans relied on for healthcare coverage, and which more than 45 million Americans rely upon today.[10] When his attempts to get Congress to repeal the law failed, Trump initiated a sabotage campaign targeting affordable healthcare. His administration made it easier to sell junk insurance: short-term and association health plans that can deny coverage for people with preexisting conditions.[11] As a result, ACA enrollment fell, and people were lured into subpar plans that didn't cover essential care like hospital visits or prescription drugs. Trump also pushed work reporting requirements and other red tape to enroll in Medicaid,[12] which jeopardized healthcare coverage for millions of people. Millions more people became uninsured or underinsured, leaving families with staggering bills for uncovered care.[13]

Meanwhile, prescription drug prices skyrocketed, and Republicans in Congress continued to block reform.[14] Rural hospital closures accelerated as a handful of states still refused to expand Medicaid under the ACA.[15] And racial disparities in healthcare

worsened with the growing Black maternal health crisis[16] and policies that discouraged immigrants from enrolling in coverage.[17]

In early 2021, Biden took immediate action to lower costs and expand care. The Biden-Harris administration reopened HealthCare.gov for a special enrollment period to help Americans gain coverage as they continued to suffer from the health and economic impacts of the pandemic. Biden also issued executive orders to strengthen access to quality healthcare and to direct federal agencies to revise Trump-era policies that undermine affordable care.[18]

Crucially, the Biden-Harris administration also moved quickly to pass the American Rescue Plan. In addition to providing robust support to combat the pandemic, it lowered healthcare costs for millions of Americans by ensuring people purchasing coverage on the ACA marketplaces pay no more than 8.5 percent of their income for coverage,[19] by eliminating premiums for those making 150 percent of the federal poverty level (about $46,000 for a family of four),[20] and by providing states with greater financial incentives to expand Medicaid. As a result of the American Rescue Plan, more than 40 million Americans had ACA coverage as of 2023,[21] many at little or no cost, and a record number of children and families were able to gain access to Medicaid. The nation's uninsured rate reached and has remained at a record low of 7.7 percent since early 2023,[22] proving that policies to make coverage affordable and accessible help more people enroll.

In 2022, Biden signed the Inflation Reduction Act,[23] a landmark law that has lowered healthcare costs for millions of seniors and families[24] by extending the ACA premium savings under the American Rescue Plan through 2025. Under the Inflation Reduction Act, 80 percent of enrollees are able to find a health plan through the marketplaces for $10 or less per month.[25] For a family of four with an income of $120,000, the law saves $6,604 on their yearly premiums; for a married couple in their early 60s with an income of $75,000, the law saves $16,000 annually.[26]

Access to health coverage is imperative to reducing coverage disparities. Historically, people of color and rural Americans have been disproportionately likely to be uninsured, which contributes to higher rates of chronic disease and poor health outcomes.[27] Lack of health insurance also increases financial instability, with an unexpected medical expense keeping people from paying rent or buying groceries.

The Inflation Reduction Act has led to coverage gains for these groups. Enrollment data show that 1.7 million Black people and 3.4 million Latinx people enrolled in marketplace coverage for 2024, an enrollment increase of 95 percent and 103 percent, respectively, since 2020—and the number of Asian American, Native American, and Pacific Islander (AANAPI) and rural enrollees increased as well.[28]

By passing the Inflation Reduction Act, Biden, Harris, and Democrats in Congress won a decades-long battle against big drug companies. For too long, Americans have paid two to four times more than people in other countries for many drugs,[29] and older adults with complex health needs have paid up to 7.5 times as much.[30] The Inflation Reduction Act was a significant step toward ending the broken system that has allowed big drug companies to charge whatever they want for lifesaving medications while seniors cut pills and skip doses because of high costs. Now, seniors are saving money because the Inflation Reduction Act:

- **Gave Medicare the power to negotiate lower drug prices.** The Biden-Harris administration is implementing the Medicare Drug Price Negotiation Program, which will lower prices for some of the most popular and expensive prescription drugs while saving taxpayers and seniors billions of dollars. In August 2023, Medicare began negotiating lower prices for Eliquis, Jardiance, Xarelto, Januvia, Farxiga, Entresto, Enbrel, Imbruvica, Stelara, and Fiasp/NovoLog, which treat conditions like cancer, diabetes, and blood clots.[31] These drugs are taken by nearly nine million people on Medicare who spent $3.4 billion in out-of-pocket costs in 2022 alone.[32] The negotiated prices for the first 10 drugs will take effect in 2026, and by 2030, 80 of the most expensive prescription drugs will have lower prices because of these negotiations.[33]

This election is pivotal for the future of healthcare.

- **Lowered insulin costs.** In 2020, more than 3.2 million people on Medicare used insulin;[34] those who did not receive financial assistance paid an average of $54 per month for this lifesaving medication. But many paid much more, with the top 10 percent of insulin users spending more than $111 per month.[35] Under the Inflation Reduction Act, monthly insulin copays for people on Medicare are capped at $35 per prescription.[36] Since the cap took effect, there has already been a substantial increase in the number of filled insulin prescriptions among Medicare beneficiaries.[37]

OFFICIAL WHITE HOUSE PHOTO BY LAWRENCE JACKSON

- **Capped out-of-pocket costs.** Thanks to the new $2,000 per year cap on out-of-pocket costs, which begins in 2025,[38] over 38 million Americans enrolled in Medicare Part D will save an average of $462 per year.

- **Ended outrageous price increases.** The Inflation Reduction Act penalizes drug companies for raising drug prices faster than the rate of infla-

Trump's policies made enrolling in healthcare coverage harder and raised costs for millions.

tion.[39] Over the past 20 years, price increases for brand-name drugs in Medicare Part D have risen at more than twice the rate of inflation.[40] This provision will not only save the government billions of dollars but also drastically reduce out-of-pocket costs for Medicare beneficiaries.

- **Provided free vaccinations.** 50.5 million seniors are eligible for no-cost vaccinations, including RSV, DtaP, seasonal flu, and the usually costly shingles vaccine. With a single dose of Shingrix (just half of the recommended vaccine) costing more than $180 in some cases, seniors on Medicare Part D saved over $400 on average on vaccinations in 2023.[41]

The Inflation Reduction Act has also served as a catalyst for additional action to lower prescription drug costs for more patients. After its passage, the three largest insulin manufacturers announced $35 monthly out-of-pocket cost caps, lowering the cost of about 90 percent of the insulin on the market.[42] And following pressure from Biden, Harris, and Democrats in Congress, two drugmakers have capped out-of-pocket costs for some top-selling inhalers at $35 per month.[43]

Centering Access and Equity

In addition to making ACA coverage more affordable, the Biden-Harris administration boosted funding for marketing and education efforts to help people enroll in coverage, with a particular focus on outreach to historically marginalized racial and ethnic groups, people in rural areas, LGBTQIA+ people, and other underserved communities.[44] In a stark reversal from the previous administration, Biden also worked to limit short-term junk plans in order to protect people with preexisting conditions and prevent outrageous medical bills for uncovered care.[45]

BRIAN STUKES / STRINGER / GETTY IMAGES

The Biden-Harris administration also fixed the "family glitch," which previously blocked millions of families from accessing affordable coverage through the ACA. The family glitch occurred when workers added dependents onto their coverage, causing premiums to rise far beyond what the law intended.[46]

Importantly, the Biden-Harris administration has pledged to protect the ACA from ongoing legislative and legal attacks. Republicans, including Trump, have reignited calls to "terminate" the ACA, which would jeopardize healthcare coverage for more than 40 million Americans and raise costs for millions more.[47] Extremists have also worked to undermine the ACA in the courts. One lawsuit (*Braidwood Management Inc. v. Becerra*) threatened to eliminate the ACA's guaranteed access to free preventive care—including cancer screenings, prenatal care, and contraception—for 150 million Americans.[48] A recent decision by the Fifth Circuit Court of Appeals leaves free preventive services at risk as the case proceeds through the legal system and opens the door to further litigation.[49]

Strengthening Medicaid has been one of the Biden-Harris administration's most significant accomplishments. About one in four Americans are covered through Medicaid or the Children's Health Insurance Program (CHIP), which serve various overlapping groups, including children, mothers, people of color, people with disabilities, working families, rural Americans, and seniors.[50]

For years, Republican lawmakers in some states have blocked Medicaid expansion under the ACA despite research showing that Medicaid expansion improves health, increases financial security, supports rural hospitals, boosts local economies, and saves lives.[51] Through the American Rescue Plan, Congress created multibillion-dollar incentives for Medicaid expansion. Under the Biden-Harris administration, North Carolina, Missouri, and South Dakota have finally expanded Medicaid, leaving just 10 states that continue to reject expansion.[52]

Thanks to their focus on improving Medicaid, Biden, Harris, and Democrats in Congress have:

- **Standardized enrollment and renewal processes nationwide.** The Centers for Medicare and Medicaid Services made it easier for millions of eligible people to enroll in and retain their Medicaid coverage.[53]
- **Protected coverage for children.** Biden signed legislation to guarantee kids can stay on Medicaid and CHIP for at least a full year before their parents must apply to renew their coverage.[54]
- **Extended coverage to new mothers.** Under the Biden-Harris administration, 47 states have expanded Medicaid coverage to new moms for a full year postpartum.[55]
- **Blocked work reporting requirements.** Biden stopped Republican efforts to rip Medicaid away from 21 million Americans with burdensome paperwork requirements designed to kick people off of coverage.[56]
- **Improved coverage and quality of care.** Through executive action, the Biden-Harris administration banned lifetime limits and waiting periods for Medicaid and CHIP coverage and enacted a regulation to shorten wait times for primary care, behavioral health and substance use disorder services, and OB-GYN care.[57]
- **Strengthened the caregiving workforce.** Biden enacted regulations to improve access to at-home care and staffing standards in nursing homes to promote safety, support the caregiving workforce, and deliver higher-quality care for seniors and people with disabilities.[58]

- **Provided maximum flexibility to protect enrollment.** Congress passed legislation in 2020 ensuring no one could be disenrolled from Medicaid during the COVID-19 pandemic, but this provision expired on April 1, 2023. As of August 23, 2024, states had removed more than 25 million people[59] from Medicaid coverage, including more than four million children[60] who had been removed by December 2023.* The Biden-Harris administration has given states maximum flexibility to keep eligible people enrolled and stepped in to restore coverage for children and hold states accountable for disenrolling eligible people.[61]

In addition to the actions highlighted above, the Biden-Harris administration has worked to address health disparities and improve healthcare for people from all backgrounds, including people of color, LGBTQIA+ Americans, people with disabilities, and rural Americans. These groups have faced greater levels of poverty and worse health outcomes due to racism, discrimination, and other systemic barriers.[62]

On his first day in office, Biden signed an executive order calling for the federal government to advance an ambitious, whole-of-government equity agenda.[63] As a result, agencies including the Department of Health and Human Services and the Centers for Medicare and Medicaid Services issued individual equity plans. These plans prioritize improving data collection and assessment of the root causes of disparities, reducing barriers to healthcare access, and expanding culturally competent care.[64]

The Biden-Harris administration has worked to strengthen mental health care and treatment for substance use disorder, creating the first-ever Department of Health and Human Services Overdose Prevention Strategy.[65] In a reversal from Trump-era policies, the Biden-Harris administration expanded healthcare to Deferred Action for Childhood Arrivals program recipients and restored civil rights protections through Section 1557 of the ACA, which prohibits discrimination on the basis of race, color, national origin, sex, age, and disability in certain health programs and activities.[66]

Protecting Reproductive Care

Reproductive care is under attack across the country. Between a growing maternal health crisis and a wave of laws restricting or banning abortion care following the US Supreme Court ruling in *Dobbs v. Jackson Women's Health Organization* (2022), which overturned *Roe v. Wade*, protecting the care of women and pregnant people is critical.

*Republican-led states have exploited this process to clear the Medicaid rolls; by December 2023, more than one million of the children who had lost coverage were in Texas, and in several states the number of enrolled children was lower than before the pandemic.

After the *Dobbs* decision, Biden signed an executive order building on previous actions to protect access to reproductive healthcare services.[67] In addition, the Biden-Harris administration has protected women's healthcare through the following actions:

- **Combating the maternal health crisis.** As the nation faces an unacceptably high and worsening rate of pregnancy-related death, the Biden-Harris administration released a *Blueprint for Addressing the Maternal Health Crisis*, a whole-of-government approach to combating maternal mortality and morbidity.[68]

- **Defending care and privacy.** The Biden-Harris administration rolled back Trump's gag rule that barred family planning providers from mentioning abortion to patients.[69] Trump's rule forced more than 1,000 clinics to lose essential federal funding and dramatically cut provider capacity.[70] The Biden-Harris rule restores funding for these providers, like Planned Parenthood, which offer essential healthcare, including sexually transmitted infection screenings and contraception. The administration also strengthened privacy laws around reproductive care.[71]

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- **Strengthening access to contraception.** Biden issued an executive order on strengthening access to affordable contraception and family planning services.[72] The Biden-Harris administration also approved the first over-the-counter birth control, which is available for purchase nationwide.[73]

- **Investing in women's health research.** The president signed an executive order directing federal agencies to prioritize women's health research, including studying conditions like menopause, arthritis, and heart disease.[74]

The Biden-Harris administration has increased financial stability for families while making lifesaving care more affordable.

It is important to recognize and reflect on how far our country has come in the last four years in terms of lowering healthcare costs, boosting coverage, and improving the quality of care. This election will be pivotal for the future of healthcare. The last administration left millions of Americans without coverage and unsure whether they could afford care. In contrast, Harris wants to build on Biden's legacy by extending the Inflation Reduction Act's drug savings to more people, closing the Medicaid coverage gap, and defending recent gains for everyone in the United States. ✚

For the endnotes, see aft.org/hc/fall2024/chaney_harris_shoup_twomey.

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