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Editors

Structural Competency in Mental Health and Medicine

A Case-Based Approach to Treating the Social Determinants of Health

🜨 Springer

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Agents of Change: How Allied Healthcare Workers Transform Inequalities in the Healthcare Industry

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The Problem

> **Poverty pay in hospitals**
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> In 2014, 2000 service and maintenance workers at Johns Hopkins Medical Center halted work for 3 days during contract negotiations. 1199SEIU called the strike to highlight "poverty wages" that forced full-time employees to obtain public assistance to make ends meet.
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> *In These Times* quoted Dr. Benjamin Oldfield, a resident who led doctors, medical and nursing students in supporting the striking workers: "[W]e know that financial insecurity leads to bad health outcomes. For a place like Hopkins, which has plenty of money, I'm surprised that they haven't gotten this one right yet" [1].
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> Source: "Striking Workers Shame Prestigious Johns Hopkins Hospital Over Low Pay." *In These Times.* April 10, 2014.

Healthcare institutions mirror society's inequalities. At almost one-fifth of the US economy [2], health industry employers generate the very inequalities that clinicians then "treat" as individual cases of illness. As a society, we value caring rhetorically but have formal structures and robust belief systems that devalue those who do care work [3]. Allied health workers have played a critical role in compelling the industry to address the structural inequalities in its own backyard. They fought workplace norms, industry rationales, and federal laws that reinforced their place at the bottom rung of the healthcare hierarchy. They transformed low-wage, dead-end jobs into living wage career ladders. Today, they are on the front lines of new

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models of care that strengthen innovative efforts in community health. This case invites clinicians to see their workplaces as sites of deep structural inequality with significant impact on workers, communities, and patient health.

Theoretical Framework

How can we end the healthcare sector's role as a central generator of structural inequalities? Allied health workers are "agents of change" who have disrupted the status quo and secured structural redistribution of resources in the industry. Breakthrough changes occurred in the 1960s when they partnered with the southern civil rights movement to bring an end to their second-class status. The industry will expand robustly in the coming decades, but most healthcare jobs remain low-wage and not unionized [4]. By sharing this history and contemporary examples, practitioners can gain insights into forging structural partnerships that match the size and scale of inequality within the industry's midst. Clinicians, along with trustees and administrators, can either transform structural barriers in the industry or perpetuate the subordinate status of many workers. The case concludes with four principles for forging effective partnerships with allied health workers.

This case incorporates the voices of the allied workforce to furnish a "bottom-up" view of their struggles to transform exploitative healthcare jobs into sustainable employment. No one is more acutely aware of the precarity experienced by these workers than the workers themselves. It uses historical and contemporary accounts of union organizing by healthcare workers in New York City and at Johns Hopkins Hospital in Baltimore to illustrate challenges to making structural changes in the industry.

The Path

Unionization is the primary vehicle to alter the structure of opportunity for low-wage healthcare workers. The allied health workforce includes all service, maintenance, and clerical positions as well as paraprofessional and professional titles, such as nurses, social workers, lab technicians, and pharmacists.[1] They are overwhelmingly female, immigrant, and people of color. 1199SEIU is the largest healthcare workers union local in the USA. Founded in 1932 as Local 1199 in New York City, this union of pharmacy workers branched into hospital worker organizing in the 1950s. The union's history captures core features of worker experiences because of the union's presence in New York City's major hospitals; its experience as a national union organizing all across the country; and its presence in nursing homes, home care agencies, laboratories, pharmacies, clinics, as well as hospitals. In 2017, it had 400,000 members in hospitals (including academic medical centers), nursing homes, home care agencies, clinics, and community health centers in five states (FL, MA, MD, NJ, NY) and Washington, DC. The Service Employees International

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[1] Definitions vary but often include sub-baccalaureate positions and jobs regarded as semi- and unskilled.

Union (SEIU) represents one million healthcare workers nationwide, including the Committee of Interns and Residents and the Doctors Council.[2]

Challenge: Healthcare Work as Low-Wage Work

Today's healthcare personnel infrastructure reflects assumptions rooted in the industry's origins in charity care and noblesse oblige. Hospitals originated in the seventeenth century in India, the Middle East, and Europe from the philanthropic impulses of monarchs, the wealthy, and religious orders. As such, they served the very poor, the disabled, the elderly, the insane, the socially isolated, and soldiers. For everyone else, healthcare occurred at home with visits from local doctors when needed. In the USA, the landed gentry (like Benjamin Franklin) and religious institutions created hospitals out of a charitable impulse to serve the less fortunate. At a later period, the connection to charity and voluntarism was further cemented when the nation's poorhouses were converted to hospitals, nursing homes, and state mental institutions. For example, New York City's famed Bellevue Hospital began as the Almshouse Hospital in 1736 [5–7].

From the outset, working in hospitals was as an act of charity. While hospitals' reliance on donations from wealthy benefactors is well-known, the compulsory "donations" of the poor to the financial viability of healthcare institutions is largely invisible. Initially, nuns and lay volunteers (often unmarried women) volunteered to feed, clean, and tend to the ill and dying. They were soon joined by impoverished former patients who stayed on after they recuperated in exchange for room and board. In addition, inmates of poorhouses were assigned to work at hospitals to earn their stay (similar to prison work release programs) [8, 9].[3] As a result, the earliest hospital "workers" were literally charity cases.

These workers' simultaneous reliance on public assistance while working at the hospital was a widely accepted norm. As hospitals grew in size, wealth, and status, nuns and lay volunteers cobbled together an informal personnel apparatus rooted in charitable paternalism to manage their growing workforce. Workers lived in hospital dormitories and basements with little privacy or time off.[4] Tasks, hours, hiring, and firing were meted out in an arbitrary blend of benevolence and reprimand, all at impossibly low wages [10, 11]. Neither workers, managers, nor trustees imagined a living wage as appropriate.

Most significantly, federal and state laws institutionalized the indentured servitude of hospital workers. In the 1930s, the American Hospital Association

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[2]There are also unions for nurses and for workers in public hospitals and healthcare centers. To learn more about SEIU affiliated healthcare unions, visit www.1199seiu.org, www.seiu.org as well as www.doctorscouncil.org and www.cirseiu.org.

[3]Prior to federal New Deal and Great Society social assistance programs, local taxes funded poorhouses that warehoused the orphaned, the homeless, the disabled, and the elderly. Residents were forced to work at nearby establishments (like rock quarries) to generate revenue as taxpayer dollars did not cover all their operating costs (see Eubanks 2018 for a brief history).

[4]For example, as part of its expansion in 1913, Mount Sinai authorized the construction of a dorm for 240 of its employees, including nurses (Hirsh and Doherty 1952).

successfully lobbied Congress to exempt nonprofit hospital workers from minimum wage laws, social security benefits, and the right to unionize [12]. In the South, hospitals were segregated. In the North, the mass migrations of African American sharecroppers from the South and immigrants from the Caribbean, Latin America, and Asia provided a new influx of poor workers who replaced the "charity cases" of a previous era.

Hospitals benefited significantly from the post-World War II economic boom. Scientific discoveries fueled their growth. In addition, they gained new revenue from private health insurance, publicly funded health programs (Medicaid, Medicare, veterans health), government research grants, and the generosity of corporate titans. Services to an expanding middle class and to wealthy patrons seeking cutting edge treatments replaced their historic emphasis on serving the poor.

The unquestioned reliance on an impoverished, charity-dependent workforce quietly subsidized the rise of the modern healthcare industry. To oversee their rapidly growing workforce, hospital leaders recruited hotel managers to join their management teams. Hospitals and hotels shared a "plantation ideal" model of services where patrons recuperated in comfort while tended to by a bevy of cooks and maids [13] (Fig. 1).
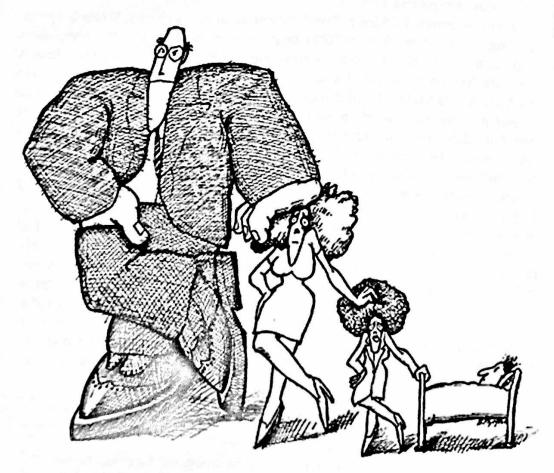

Fig. 1 The healthcare hierarchy. (Source: Illustration by Bill Plympton for Health Policy Advisory Center. Circa 1970 in *Health/PAC Bulletin*. Access at http://www.healthpacbulletin.org/plymptoons/. Credit ©The Health/PAC Digital Archive. Permission pending)

In this social and historical milieu, the paternalism of charity care easily married with the social practices of Jim Crow. A Department of Labor study of hospital wages in 16 metropolitan areas in 1956–1957 found low salaries as the norm, with New York City paying an average of 84 cents an hour with female workers in similar jobs earning even less [12]. Only five locations in the USA paid over $1.00 an hour. Journalist A.H. Raskin noted that, "...it was a tragic joke in the hospitals that none of their nonprofessional employees could afford to be sick" [14] (Fig. 2). An industry assessment concluded:

> Hospitals have long been the urban employer of last resort. The newcomers, the discriminated-against, those who are excluded from other jobs are likely to end up as porters, nurses' aides, orderlies, kitchen help, housekeepers, and the like, in the immense and rapidly growing hospital industry. ... Hours are long, duties dirty and boring, job security non-existent. ...[T]urnover rates often approach 90 percent per year. [15]

By the 1950s and 1960s, the gendered and racial pay gaps reflected the firm hierarchy of race, gender, and class that structured the system. Pay gaps institutionalized "common sense" beliefs that perceive care work (including child care, teaching, and domestic work) as natural extensions of women's roles as mothers and classified it as "unskilled" or semiskilled labor. This web of laws, social practices, and popular beliefs reinforced the assumption that these workers should be grateful to work under any condition without complaint.

It is well knowm that the hospital worker hierarchy features well paid, highly trained, white men at the top; intermediate paid, largely white, women in the middle: and poorly paid, black and brown women at the bottom. The following chart gives the details.

Job	% of total Employment (1)	% of total payroll (1)	pay range ($ per week) (2)	approximate % female (3)	approximate % non-white (4)
management/supervisory	9	13	200-500	15-20	10-20
academic	2	5	200-400	20	5
interns/residents	6	9	180-250	10	8
staff RN's	21	25	155-170	98	40
Lab techs	10	9	135-165	75	40
LPN's	7	7	110-130	85	90
clerical	11	8	100-130	85	60
aides/manual service	34	24	95-115	80	80

Notes: (1) figures refer to New York University Hospital; (2) figures are for New York City short-term, non-governmental hospitals, spring 1970; (3) figures are for U.S.; (4) figures are for New York City Municipal hospitals.

Fig. 2 Gender and race hierarchies reflected in hospital pay scales. (Source: Data compiled by Health Policy Advisory Center researchers. In "Hospital Unions: A Long Time Coming." *Health/PAC Bulletin*. July–August 1970. See www.healthpacbulletin.org. Credit ©The Health/PAC Digital Archive. Permission pending)

These structures persist. In 2014, as 1199SEIU negotiated a contract with Johns Hopkins Hospital, workers shared their stories of living in homeless shelters or doubled up with relatives. Others faced eviction and received food stamps and other forms of public assistance to make ends meet (see www.hardshipathopkins.org). Today's home care industry also reflects a marriage of work and welfare. Initiated in the 1970s as an innovative welfare to work experiment, the federal government's new home care program required welfare recipients to care for poverty stricken, homebound elderly and disabled patients [16, 17]. Consequently, the low wages of this female workforce produced significant savings while addressing a growing healthcare need. Today, many home care workers are disproportionately women of color, immigrant and undocumented. Those with legal status often earn minimum wage and rely on public assistance (such as public housing and food stamps) to make ends meet.

Response: Unionization Because Workers' Lives Matter

Durable structural inequality at Johns Hopkins 1969 and 2014

Annie Henry, an instrument processor, remembers when she and her co-workers at Johns Hopkins voted to unionize in 1969. Only on staff for 6 months, she recalls, "I was ready to quit. The hospital was like a plantation. You couldn't even talk to supervisors." She and other workers were heartened when the recently widowed Coretta Scott King stood with them during the 1969 strike which linked the fight for civil rights with worker rights.

Annie also participated in the 2014 strike at Johns Hopkins and lamented: "Never in forty-five years did I think I'd still be doing this. We want to be paid our worth."

Sources: "50 Who Carried the 1199 Torch: Profiles of our Pioneers," *Our Life and Times: A Journal of 1199SEIU*, December 2009 and "Baltimore Since Beth Steel: Hopkins Hospital Workers Fight for 15," *Dissent*, June 26, 2014.

By the 1950s, healthcare workers were treated as disposable workers with jobs characterized by high turnover and total subservience. Workers found the ability to question the status quo and the courage to confront this oppressive system in collective action. In 1958, after decades of winning victories for pharmacy workers, Local 1199's membership voted to focus on the hospital sector to end the exploitation there. The union's organizing staff spent a decade cajoling and persuading hospital workers to believe in their own worth. Hospital workers drew direct inspiration and support from the civil rights movement in the South. Dubbed "Soul Power," the union combined classic tactics of worker organizing with the rhetoric and strategies of civil rights activism [13]. They began to see their situations in structural rather than individual terms, rejecting the ideology of individual efforts as *the* path to success (Fig. 3).

In 1968, 1199 members won the nation's first ever hospital worker contract. It tripled wages (to a minimum of $100 a week) and provided healthcare, pension, and education benefits to 40,000 members at multiple New York City hospitals.

Fig. 3 "Soul Power" – Civil rights and workers' rights. *The recently widowed Coretta Scott King (center) marches with hospital workers in Charleston, South Carolina during their 1969 strike. She is joined by Mary Moultrie, a nurse's aide and president of South Carolina 1199B (second from the left) and Doris Turner, president of Local 1199 (first on the right).* (Source: 1199 photo archives. Credit: © Jim Tynan. Reprinted with permission)

Professional titles joined the union because as Ann Flack, a registered nurse noted: "...nurses wanted what the unionized maintenance staff had" – paid sick days, regular time off, benefits, and a voice in improving patient care [18].

1199 launched a national campaign to unionize hospital workers across the nation. By 1985, 150,000 members in 20 states joined the union. The turn to unions meant workers no longer relied on the kindness and charity of individual supervisors in their efforts to get a fair deal. The power of their collective voices proved to be the only the vehicle to obtain concrete and lasting results.

Challenge: Employers Defend the Status Quo

Healthcare leaders' paternalism seek to preserve and protect the status quo
"This is not a strike, but a revolution against law and order."
 Greater New York Hospital Association, 1959
 Source: "1852–2002: The Sesquicentennial," Mount Sinai Hospital 150th Anniversary Committee (2002: 23).

Employers vigorously defended existing norms when confronted with worker demands instead of interrogating the assumptions of the socioeconomic system they inherited. In 1958, every nonprofit hospital in New York City (except one) refused

to allow their workers to vote on unionization. In a 1959 letter, Mount Sinai's leadership explained: "A hospital is not an economic, industrial unit. It is a social unit. … Human life should not be a pawn in jousting for economic gain or power." Hospital executives asked, "…strike against whom—our patients, sick people, children needing immediate medical care!" [19]. In 2014, Johns Hopkins's president, Ronald Peterson, conveyed the sentiments of a benevolent employer who saw current arrangements as essentially fair, even exemplary. In an op-ed in *The Baltimore Sun*, he insisted that each employee is "…part of our team and vital to the world-class care we provide." He lauded existing wages for service and maintenance workers for being above the federal ($7.50) and state ($10.10) minimum wages. He drew attention to health benefits and educational programs that give unskilled, low-wage workers and their families opportunities for self-improvement [20]. Others suggested that the requested $15 minimum wage would cost Hopkins $3 million annually, a small fraction of its reported $145 million surplus [1, 21].

Response: Strikes Compel Change from Charity to Justice

Strikes and civil disobedience – violating existing laws to get justice – yield results

From the *New York Times* obituary on Leon Davis:

…[He] was more than a founder and president of Local 1199 of the Drug, Hospital and Health Care Employees Union: he was a virtual patriarch to its generations of clerks, janitors, aides, orderlies, laundry workers, porters, dishwashers, elevator operators and other low profile employees in hospitals, nursing homes and pharmacies. In a turbulent half-century at the helm, he led major walkouts in New York in 1959 and 1962 and in Charleston, S.C., in 1969, was twice jailed for defying anti-strike injunctions, helped overturn Federal and state laws that exempted health care workers from collective bargaining, and was instrumental in raising the wages, working conditions, living standards and dignity of thousands he called America's forgotten workers [22].

Source: "Leon Davis, 85, Head of Health-Care Union, Dies." *The New York Times*. September 15, 1992.

Workers faced an enormous power imbalance economically, socially, and ideologically. They were excluded from all labor protections and it was illegal for them to strike. To end their invisibility, pierce the veil of complacency, and get their side of the story out to the public, workers went on strike. Because reasoned arguments failed, strikes proved the only effective vehicle to gain public attention to the immorality of accepted norms.

Six months after virtually every hospital refused to allow workers to vote for a union, 3500 workers from seven New York City nonprofit hospitals went on strike for 46 days. Employers created a committee to discuss their demands. After 3 years

of dialogue, no changes in working conditions resulted. A second city-wide, multi-employer strike occurred in 1962 and lasted 56 days. The 113-day strike in Charleston, South Carolina, in 1969 resulted in 1000 arrests, hunger strikes in jail, and national television coverage [13].

The need to strike persists. In 2014, Johns Hopkins endured months of negative mainstream and social media attention to its poverty wages, including a 3-day strike and a high-profile Mothers' Day March and Rally that featured worker testimonies and support from celebrities like Danny Glover. To avert a second 3-day strike, Maryland's governor intervened and forced the parties to the negotiating table where they successfully settled. Union members with 20 years or more of experience received an immediate $15-an-hour minimum wage. Others would make at least $13 an hour by 2018, well above the $12.25 minimum Hopkins offered [23].

Health care workers continue to rely on public assistance to survive

Kiva Robbins, an environmental services worker at Johns Hopkins Hospital, in her letter to the editor of *The Baltimore Sun* asked: "Is it fair that workers who spend their entire careers in dietary or housekeeping jobs must live in poverty?" She wondered why her salary was only $12.20 an hour after 12 years of service. She had taken advantage of educational opportunities and earned a certificate, but she could not afford the child care she needed to take additional college classes to earn a degree. Moreover, she found Johns Hopkins's fabulous healthcare benefits "beyond my means" and instead relied on "Maryland taxpayers and the state's medical assistance program" for providing healthcare for her two sons [24].

Source: "Struggling Hopkins Workers Need Better Wages, Not Unusable Benefits," *The Baltimore Sun*, April 15, 2014.

Asking low-wage workers to "get an education" so they can qualify for a job that gives them respect and financial reward presupposes that the key roles workers currently play in the daily work of running our institutions is meaningless and not valuable. Wage increases don't fully address persistent structural inequality, given the low starting point and the impact of inflation. Observers noted that the 2000 Johns Hopkins employees won't exactly be "flush with cash" [25].[5] To stay afloat, many work a second job and pool their income with other family members while hoping that job loss, eviction, illness, death, or an unexpected life event doesn't occur.

Benefits place the promise of the American dream within reach of ordinary workers. They are key mechanisms to convert dead-end jobs into an entry point to a genuine career ladder. Leon Davis, 1199's founding president, conceptualized the "Funds" as organizations 100% funded by employer contributions that provide a

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[5]Even in 1969, workers like Mrs. Mozell Smith, a 50-year-old food preparer at Hospital for Joint Diseases, recognized that winning $107 a week is "not a lot of money, but it's a lot if you're used to getting $65" [14].

range of services to union members based on terms in the negotiated contract. Funds have been replicated across many unions since. These examples are largely from 1199's contract with the League of Voluntary Hospitals and Nursing Homes based in New York City [26].[6]

- *National Benefit Fund (healthcare and pensions)* – The Fund receives employer contributions that finance the administration of services ensuring no out-of-pocket costs for medical and dental care and prescriptions. When the cost of healthcare is shifted onto employees, workers find themselves with healthcare in name only.[7] Pensions ensure that workers receive benefits in addition to their social security earnings when they retire.
- *Training and Upgrading Fund (education)* – Created in 1969 as the first of its kind in the nation, this Fund ensures access to no- or low-cost continuing education with supportive counseling, scholarships, and tuition support for high school diplomas, college degrees, certificates, and licenses. It has been replicated in union contracts in many industries across the country. Today, the Fund is training members for new positions, such as patient navigators, care coordinators, and community health workers.
- *Job Security Fund (layoffs)* – In anticipation of massive layoffs in the 1980s, 1199 created a service to give laid off workers a means to provide for their families, while they receive counseling and classes to find another job in the industry.
- *Child Care Fund* – Noticing rising child care costs, members negotiated the creation of new Fund to furnish low-cost access to summer camps, college scholarships, and youth mentoring services for their children.
- *Homeownership and Citizenship Classes* – Administered by the Training Fund, the classes coach and support people through all the stages of obtaining a mortgage and/or US citizenship.
- *Labor-Management Committees* – Workers and supervisors jointly identify projects that simplify operations and improve patient care through hundreds of successful projects that result in millions in savings. Dedicated staff train committee members in collaboration, communication, and problem-solving.

Negotiated benefits combat the structural deficits workers face. They convert jobs defined by a constant state of economic precarity into avenues for moderate stability. But most workplaces are not unionized, or workers lack the power to threaten a strike, which has been the only effective way to make gains at scale. Recognizing that all workers – not just union members – face structural challenges, most unions join coalitions to increase standards for all workers by supporting new minimum wage laws, health and safety regulations, universal pre-K, disability rights, family medical leave laws (paid and unpaid), and, of course, universal healthcare.

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[6]To learn more, visit www.1199seiubenefits.org/.

[7]Evelyn Harris, an emergency room liaison at Niagara Falls Memorial Hospital in Buffalo, NY reported: "Fifty percent of our service and maintenance workers at Niagara Falls Memorial [Hospital] go without healthcare coverage because they can't afford it." "Profits Before Patients: Many HMOs earn billions while cutting services and increasing premiums." *1199SEIU Our Life and Times.* May 2007: 7.

Despite the pain of the historic New York City strikes, hospital leaders belatedly acknowledged that unionization reduced employee turnover, increased worker pride, and raised performance standards. They admitted: "Many...work stoppages relate to actions of unwise supervisors. All supervisors have had either to respond to training in supervisory practices or be fired" [27]. Observers noted that, "Hospitals now retain personnel experts and improve their whole approach to human relations, to the benefit of patients as well as workers" [14].

Challenge: Ignoring the Impact on Patient Care

> **Caring for patients is not over when your shift ends**
> Home Health Aide Melisa Saigo notes, "[their] life is in our hands; we can't just leave when our shift is over... but often we only get paid the flat rate even if we work longer..." [28].
> Source: Interview with Sandi Vito, April 2017.

Allied healthcare workers interact with patients at moments of deep vulnerability. Nurse aides, orderlies, and others listen to patients, console them, and respond to their needs while cleaning, bathing, feeding, and monitoring them. These workers receive a clear message that the "emotional labor of chatting, sharing stories, spending time, and being a friend" is not important. It is "not reflected in job descriptions, supported by administrators, taught in training, or rewarded in pay." Nor is it considered "billable" on official charts [29]. Nurses find difficult work conditions where they take orders from doctors and do more "'paper care than patient care'" [29].

Today workers feel coerced to give their time to preserve the dignity of patients. Unrealistic workloads mean time runs out, while workers are in the middle of bathing a client, doing laundry, or buying groceries. Workers face the moral burden of deciding whether to "'dip into the well of their own humanity to offset budget constraints and stifling rulebooks'" by staying late and arriving early to meet patient needs [29, 30].

Response: From Workers to Partners in Care

> **Frontline workers are best positioned to teach and foster social medicine**
> Lloyd Conliffe, Care Manager in Brooklyn and 1199 member, reported that the care coordination team found that, "If you don't have anywhere to sleep, you won't go to the doctor." But it took time for "doctors [and medical students] to understand the social parts of medicine" – the idea that family, social supports, and housing are important parts of health [31].
> Source: Interview with Sandi Vito, January 2017.

Inadequate staffing ratios are a long-standing problem. Undervalued work and chronic understaffing also fuels rushed, harried, neglectful, and rude care. In

addition, workers easily find their ideas and insights are not welcomed or valued. One vehicle 1199 institutionalized to address this lack of voice is the Labor-Management Committee. As a result, allied health workers can be recognized as partners who address structural barriers in healthcare by using their ability to connect with patients' lives. Two examples highlight the result of promising initiatives that address structural barriers in healthcare by engaging workers' ability to connect with patients' lives.

- *Care Managers in Brooklyn, NY.* The Brooklyn Health Home project at Maimonides Medical Hospital seeks to improve health outcomes in 11 zip codes. In the newly created role of Care Manager, allied health workers function as advocates who "show people where to get assistance and how to navigate systems, as well as teaching patients to advocate for themselves" [31]. Care Managers identified housing as a healthcare issue and shared it with the care team, community networks, and testified at public hearings. Initially, doctors failed to recognize the value of health coaching, coordination of care, and connections to social services to address housing and other problems. But relationships strengthened over time, and key physicians began to educate others about the importance of housing to improving care.
- *Community Health Workers in Bronx, NY.* Bronx-Lebanon Hospital's Family Medicine Program recognizes that patients live in an interconnected web of family and neighborhood dynamics that are influenced by community organizations as well as city, state, and federal policies [32]. The project reaches patients not engaged in primary care and increases follow-up by current patients. Newly designated community health workers helped residents identify the priorities that would improve health, and then they built linkages with over 20 organizations that could address identified needs. A range of programs resulted, including youth leadership development and arts internships, exercise classes, healthy living groups, and senior citizen art groups. The Apprenticeship Program creates a meaningful entry point and career ladder and reflects a deep partnership between the union and employers [32, 33].[8]

It remains to be seen whether these pilot projects will remain small-scale experiments or function as beachheads that grow into large-scale programs that alter the mainstream experience of care.

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[8] See Destina Garcia's story profiled by Kevin Carey in *The New York Times*. The Apprenticeship Program is a partnership between 1199SEIU Training and Employment Funds, Bronx-Lebanon Hospital Center, 1199SEIU United Healthcare Workers East, LaGuardia Community College, and the New York Alliance for Careers in Healthcare. "Trump's Apprentice Plan Seems to Need a Mentor," Kevin Carey September 28, 2017. https://nyti.ms/2yuszuY.

Key Learnings: Agents, Allies, and Mavericks Seeking Structural Change

Charity has its limits

The Baltimore Sun observed, "Johns Hopkins University has been at the vanguard of efforts to improve East Baltimore through charitable work, so why not start with health care workers?" [23].

Source: "A Win-Win for Hopkins," Editorial, *The Baltimore Sun*, July 8, 2014.

For social, cultural, economic, and historic reasons, the healthcare industry – like many other employers – takes the low road with their employees, maximizing income at the expense of individual and societal health. Unionization is the exception. More often charity, benevolence and philanthropy reign. But those approaches have not reduced structural inequalities for healthcare workers at scale. Nor has heartfelt appeals to justice, fairness, and rights. Rising through the ranks by acquiring more degrees and certificates has not been an effective strategy for many workers. The rungs in the ladder of educational opportunity are broken, leaving many debt-ridden and underemployed. Overall, offering individual rewards to "good" and "deserving" workers does not address structural inequality.

Workers acting as "agents of change" through unions and broad based social movements have been the most effective driver of large-scale change that reduces structural inequality. In 2018, nurses at Johns Hopkins Medicine and graduate students at Johns Hopkins University pursued unionization [34, 35]. Collective actions – such as marches, rallies, lawsuits, social media campaigns, and, as a last resort, work stoppages – have been necessary but not sufficient.

Allies are critical. In the 1950s and 1960s, donations from other unions, neighbors, churches, and supportive organizations allowed workers to avoid starvation and homelessness during strikes. Allies – especially governors and other elected officials – also exerted pressure on employers to urge them to settle [10, 13]. For example, Martin Luther King, Jr. called New York's Governor Nelson Rockefeller to urge him to keep his promise to repeal the law that made hospital worker strikes illegal [13]. Smaller actions count, such as the letter of support for striking workers signed by Johns Hopkins physicians and published in *The Baltimore Sun* [36].

Mavericks also help. Typically, trustees resist changing their employment practices and prefer to rationalize the ongoing poverty of allied healthcare workers [37]. Sometimes, maverick board members disagreed with their peers and took public stances. For example, Dr. Martin Cherkasky, CEO of Montefiore Hospital in the Bronx (New York), was shunned by colleagues after persuading the board to permit hospital unionization in 1958 [38]. Influential Congressman Emanuel Celler resigned from a hospital board because they authorized arrests of striking workers [10]. Perhaps a new generation of clinicians and healthcare leaders will spearhead an approach where the industry no longer generates the very inequalities it subsequently "treats."

Application: Building Alliances with Healthcare Workers for Structural Change

The healthcare industry is not unique in its reliance on society's low-wage structures as central to its financial and care delivery models. Industry leaders can learn to see and transform the inherited hierarchies of class, race, gender, and status *within* medical settings. Collaborations with allied healthcare workers will be essential to achieve fairness and health at scale.

1. *See workers holistically and cultivate genuine partnerships.* Forging effective partnerships with healthcare workers can be a key component of achieving structural competence and system transformation. Workers are also patients, family members, community leaders, advocates, taxpayers, neighbors, and voters. Healthcare workers are deeply invested in ending the perversities that plague our healthcare system and our society. Creating meaningful patient, worker, and community collaborations at scale is new to the industry. To avoid superficial engagement, healthcare organizations must partner with experienced entities like labor unions and grassroots groups with a track record of building community-based partnerships with healthcare entities (see, examples at www.community-catalyst.org or www.interactioninstitute.org). The presumption that those with the most resources have the best or most appropriate answers must be set aside for real engagement with those who work on the front lines.

2. *Reinvest savings to cultivate community and population health.* As the country with the most expensive healthcare system and the worst health outcomes, savings are both possible and necessary. The ideas of patients, workers, and communities can lead to significant savings and improvements. When workers' ideas make a difference, institutions should share the rewards, not just the burdens of problem-solving. Savings should be reinvested to support and cultivate healthy patients, workers, and communities. Furthermore, better patient care at lower cost should not occur at the expense of workers who have benefited least from the industry's wealth. Too often the search for savings perpetuates historic inequities as financial pressures lead institutions to squeeze workers at the bottom of the hierarchy to compensate for inefficiencies generated by the fragmented fee-for-service system [39, 40].

3. *Guarantee free healthcare for all healthcare workers.* Eliminate high co-pays and deductibles for employees in the healthcare sector. With over 200,000 members in New York City, our data shows they also suffer from chronic healthcare problems (heart disease, diabetes, high blood pressure). Allied health workers often work at the expense of their own health. In addition, other possible interventions by employers include substantive health and wellness of their employees. In addition, they can forgive the medical debt of their low-wage employees. Employers can also voluntarily divulge the number of employees receiving public health insurance and social assistance.[9]

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[9] See Walker, Andrea K. 2014. "Union wants hospitals to disclose employees on public assistance." *The Baltimore Sun.* May 21. www.baltimoresun.com/health/blog/bs-hs-union-hscrc-20140521-story.html.

4. *Support organizations and policies that improve the lives of all workers.* Speak out in big and small ways on the connection between a good job and good health. Support structural interventions such as affordable housing, paid sick days and family leave for all, universal pre-K and child care, a $15 minimum wage and pay equity, climate justice and disability rights, anti-violence and anti-police brutality initiatives, and universal education and healthcare. Fair access to the structure of opportunity is essential. Through unions and alliances with other social movements, healthcare workers forced systemic changes that gave working families a chance at the American dream.

Appendix

In the Classroom

We need healthcare practitioners with the skill to build a robust and just health system. Classroom activities can include:

- *Guest speakers*: To build awareness of workforce relations and the social dimensions of medical care. Seek multiple perspectives on the same issue.
  - *Unions and worker organizations*: Their elected officers, activist workers, and their policy, research, communications, and organizing staffs can offer valuable perspectives. For worker experiences, arrange for guest speakers (workers need an honorarium for these visits) or create "a day in their shoes" experiences shadowing community health workers, home care workers, and other key allied health workers. Use documentaries and videos to bring worker experiences into the classroom.
  - *Worker organizations*: Home care worker growth outpaces all other categories in the next decade. The national campaign, Caring Across Generations, seeks to build a true system of affordable long-term care and build a culture of care.
  - *Training funds*: They critically analyze industry trends and work with both management and labor to offer relevant interventions. See, for example, www.1199seiubenefits.org.
  - *Employer and industry organizations*: They negotiate with unions and represent multiple employers. In New York City, it is the League of Voluntary Hospitals and Homes (www.lvhh.com) and the Greater New York Hospital Association (www.gnyha.org/).

- *Administrators*: Their mindsets and decisions affect thousands of workers and patients. Include "middle managers" responsible for implementation on the ground.
- *Trailblazers*: Institutions that have implemented innovative workforce or care delivery changes at scale, like Kaiser Permanente.
- *Network and capacity builders*: Building a better future for healthcare with community partners takes deep skill to avoid typical pitfalls and to identify grounded and sustainable innovations. Ideas, resources, and tools are available from www.communitycatalyst.org/ and www.interactioninstitute.org/.
- *Academics*: To build a conceptual vocabulary and critical analysis that integrates historical, economic, and sociological dynamics with healthcare delivery. See the citations in the "Agents of Change" chapter.
- *Patients*: To excavate the range of interactions they have beyond the clinical encounter. In addition, seek nursing home and home care patients as well to engage questions of continuity of care and of the social factors that influence the receipt of care and adherence to treatment plans.
- *Historical cases*:
  - *Johns Hopkins Medical Center Strike 1969 and 2014*
    Video of Annie Henry talking about Coretta Scott King at Johns Hopkins strike in 1969. http://hardshipathopkins.org/coretta-scott-king-at-hopkins/ 2014 accounts of the Johns Hopkins strike. Available at www.hardshipathopkins.org
  - *1969 Hospital Strike in Charleston, SC*
    Documentary: *I Am Somebody* (30 min), directed by Madeline Anderson, a trailblazing African American female director. http://icarusfilms.com/if-iams Primary sources including audio clips of interviews – http://ldhi.library.cofc.edu/exhibits/show/charleston_hospital_workers_mo/sources_3
  - *Health Policy Advisory Center*
    From 1968 to 1994, the Health Policy Advisory Center provided critical analysis of the medical industrial complex, a term they coined. Their articles and books investigate the industry's structure as well as grassroots community-based efforts to combat inequality. There archives are accessible and searchable online at www.healthpacbulletin.org.
    Cartoons on the healthcare industry by award-winning illustrator Bill Plympton www.healthpacbulletin.org/wp-content/uploads/2013/02/H-PAC-Bill-Plympton-Drawings-Scanned_007.png
  - *Podcast on history of Bellevue Hospital as almshouse hospital* – http://boweryboys.libsyn.com/-152-bellevue-hospital
- *Read healthcare worker contracts*: Learn the concerns of workers and the benefits and protections negotiated. For example, see 1199SEIU's master contract with the League of Voluntary Hospitals and Homes of New York at lvhh.com/current-agreements/.
- *Write accessible pieces like letters to the editor and op-eds*: Choose an issue and write it. Sending is optional but practicing helps. Given today's technology, op-docs, blogs, and other vehicles for sharing perspectives also matter. See, for example, "Invisible Colleagues" by Benjamin Oldfield, MD in *The New England*

Journal of Medicine August 27, 2015. www.nejm.org/doi/full/10.1056/NEJMp1506873.

- *Awareness and reflection*: It's disturbing and disruptive to learn we have blinders. Build awareness and the capacity to hold uncomfortable truths and contradictions via workshops and exercises with partner organizations dedicated to such learning. Class action's workshops and resources on class (classism.org) and racial justice trainings (this is not diversity training) (https://www.raceforward.org/trainings; http://interactioninstitute.org/trainings/).

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