CHICAGO HOSPITALS DUAL CRISIS:

Disinvestment in Communities, Disinvestment in Workers.

SEIU HCII
Illinois ▪ Indiana ▪ Missouri ▪ Kansas

INTRODUCTION

Two accelerating trends have created a crisis in Chicagoland hospitals. Disinvestment in hospitals in working-class communities of color has left these institutions hard-pressed to meet the vast health needs in the communities they serve. Disinvestment in the healthcare workforce has led to an industry-wide staffing crisis that harms both workers and patients.

The context for this disinvestment is a highly economically polarized hospital industry, in which vast resources that could otherwise expand access to care for vulnerable populations and fortify the hospital workforce have become concentrated in the hands of a few large hospital conglomerates, known as "health systems." We as a society entrust huge responsibilities for the health of all people to these private-sector actors, along with immense financial resources.[1] But with system-wide investment decisions largely determined by a few powerful health systems with limited input from or concern for other stakeholders, the distribution of resources within the hospital industry has become organized primarily around wealth accumulation, not an overarching plan to meet community health needs or support the healthcare workforce.

Health systems do not operate in a vacuum, however. Their business decisions reflect regulations and incentives designed by policy makers at the state and federal levels. Currently, these policies reward hospitals for reducing the time and labor devoted to each patient. The labor-intensive care required by vulnerable populations, which often becomes the primary function of safety net hospitals, is deprived of adequate financing and support. Care work, and those who perform it, have been devalued by policy makers seeking to limit healthcare expenditures. Meanwhile, health systems have accumulated enormous wealth by marketing capital-intensive procedures to relatively wealthy populations.

It is in this policy landscape that both threads of the healthcare delivery system disinvestment crisis have emerged:

- Disinvestment in Vulnerable Communities – Health systems have withdrawn resources from the communities most impacted by health disparities or have avoided these areas outright. The safety net hospitals serving these communities have struggled to remain economically viable.
- Disinvestment in Hospital Workers – Health systems have deprioritized investment in workforce, and safety net hospitals often lack the resources to maintain adequate staffing levels. The result is a nearly universal staffing crisis across wealthy and under-resourced hospitals alike, that harms both workers and patients.

While many essential services in the US are acutely underfunded, this cannot be said for the hospital industry. Instead, hospital services suffer from severe resource misallocation. In Chicagoland, this has resulted in a de facto system of racial redlining, as health systems have avoided investing in communities of color, limiting access to care and contributing to racial health disparities. It has also created significant workforce challenges, with widespread understaffing and workers feeling burnt out and undervalued. As this dual crisis is largely a result of public policy that facilitates health system behavior, lawmakers at the state level have a chance to address it. By holding health systems accountable to workers and communities, we can overcome the disinvestment crisis and build a system in which all hospitals are fully funded and where hospital workers are properly valued.

PART 1

Disinvestment in Vulnerable Communities

Racial health disparities in Chicagoland have been well documented and are among the most severe in the US.[2] Health outcomes vary substantially depending on zip code, race, income, and language spoken. This includes the much-discussed life-expectancy gap between the white and wealthy Streeterville, where the average resident lives to be 90, and the South Side neighborhood of Englewood, where life expectancy is below 70.[3] Racial disparities in infant and maternal mortality have also been well documented. A 2019 report by the Chicago Department of Public Health (CDPH) found that black women in Chicago have almost six times the pregnancy-associated mortality rate of white women.[4] Another CDPH report found that infant mortality is more than twice as high among Black Chicagoans than among other city residents.[5] Rates of chronic disease are much higher in Black communities than in whiter areas of the city. Diabetes rates, for instance, are over 20% in much of the South and West Sides, whereas, in many areas of the North Side rates are below 5%.[6]

While these health disparities are rooted in a wide range of social and economic inequities, inadequate health care access in communities of color is undeniably a primary factor. Hospitals play an essential role in the communities most impacted by health inequities, serving as providers-of-last-resort for residents with poor access to primary or preventive care**.** Yet, the massive wealth of Illinois' health systems is largely missing from these communities. At the publication of this report, only one hospital in the city of Chicago affiliated with a major health system is in a majority Black zip code.[7] Making matters worse, hospital services have been receding from these communities for decades. Since just 2015, three Chicagoland hospitals have closed in diverse, working-class suburbs: Westlake Hospital in Melrose Park, Metrosouth Hospital in Blue Island, and Franciscan St. James in Chicago Heights. Obstetrics units have closed at four

South Side hospitals: Jackson Park Hospital, St. Bernard in Englewood, Holy Cross in Chicago Lawn, and Provident Hospital in Bronzeville. Another Bronzeville hospital, Mercy Hospital and Medical Center, was nearly shut down during the COVID-19 pandemic before it was sold by the health system Trinity Health for just one dollar.

Wealthy health systems largely refuse to invest in communities of color because they do not believe they will turn a profit. Instead, they invest these resources in whiter, wealthier communities where there are large populations of commercially insured patients. As these health systems control the vast majority of hospital industry resources, this has led to a de facto system of racial redlining. The result is snowballing inequality at the institutional level, as wealthy hospitals get wealthier and safety net hospitals are left behind, and at the system level, as hospital services become increasingly clustered in the wealthier areas of Chicagoland.

Health System	Investment Fund
Ascension	$19,478,383,000
Advocate Health	$10,704,980,822
Northwestern Memorial HealthCare	$9,350,882,000
Trinity Health	$5,266,635,000
Endeavor Health (previously NorthShore)	$4,402,164,267
OSF HealthCare System	$2,227,679,460

TABLE 1: Investment funds of health systems with a footprint in Chicagoland. Data compiled from IRS 990 filings and publicly available financial statements from most recent year.

LAKEENA WHITFIELD

EVS, St. Bernard

My name is Lakeena Whitfield and I worked in environmental services at St. Bernard Hospital, a safety-net hospital located in Englewood on Chicago's South Side, during the onset of the COVID-19 pandemic. Because St. Bernard is a poorly resourced safety net hospital, we lacked the necessary resources (including PPE and ventilators) to handle the mass influx of critically ill COVID patients. But when we reached out to well-resourced big system hospitals about transferring patients, they often failed to answer or refused to accept our transfers. We had to watch patients die who may have lived had we been able to transfer them to a big system hospital that had the necessary capacity and equipment to save them. The disparity of resources between St. Bernard and the big system hospitals also put workers like me at risk. At. St. Bernard, a lack of PPE forced EVS workers to reuse gowns, potentially exposing themselves, other workers, and patients to COVID-19. The marked disparity in resources to fight the pandemic between St. Bernard and the big system hospitals was unfair to us, and it was unfair to our patients.

Racial Redlining and the Geography of Investment

Figure 1 shows the hospitals affiliated with major health systems in Cook County against the Black population of each census tract. All suburban hospitals are affiliated with major systems, and all but three of the 13 non-affiliated hospitals are located in Black communities on the South or West Sides. In 2022, all independent hospitals in Chicagoland were classified as safety net hospitals, which generally means that the majority of their patients are covered by Medicaid.[8]

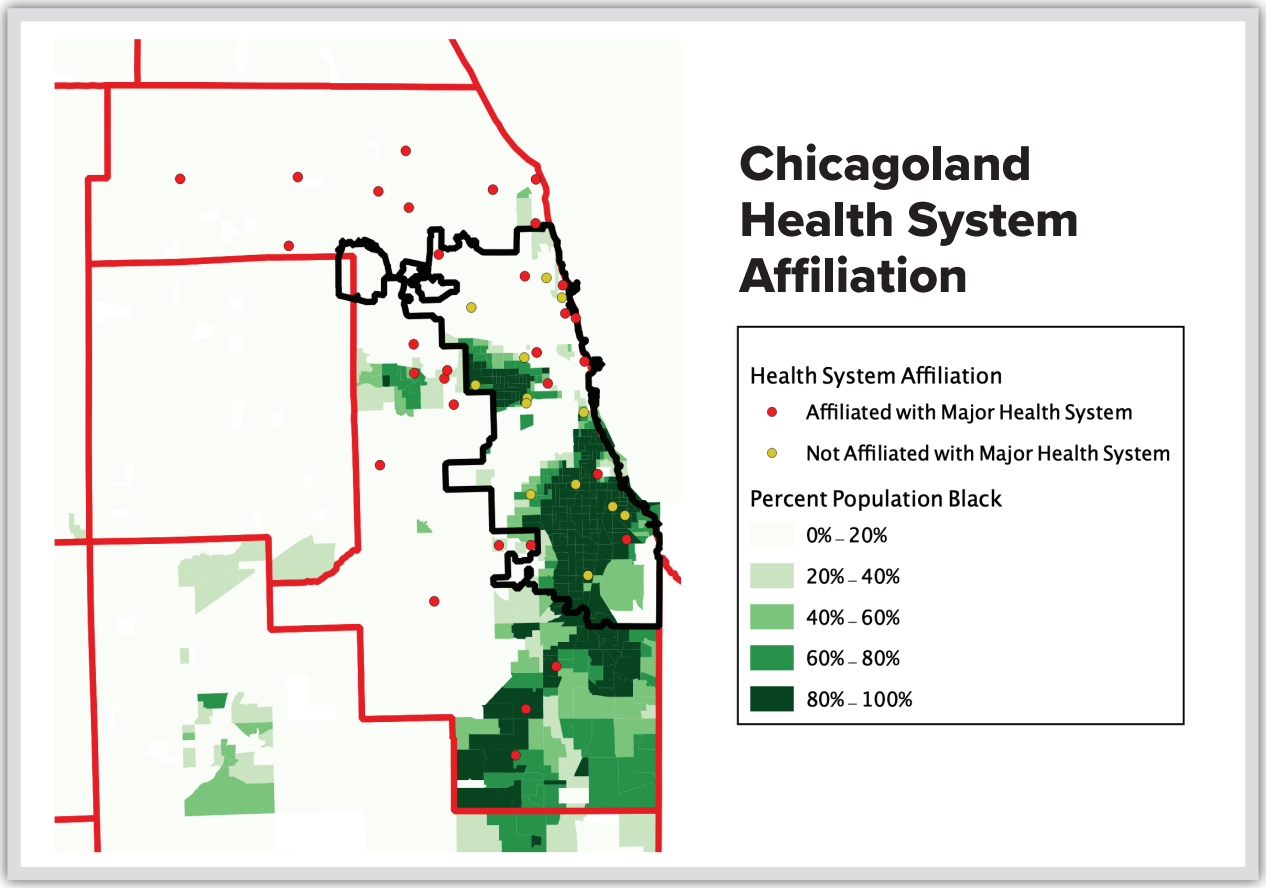

FIGURE 1: Hospitals by System Affiliation

These independent safety net hospitals struggle to make the investments necessary to maintain their facilities and equipment. Table 2 compares the capital investments made by these hospitals from 2020 to 2022 compared to system-affiliated hospitals in wealthier parts of the metropolitan area.

Hospital	Location	System	Capital Investment 2020-2022
St. Bernard	Englewood, Chicago	Independent	$7,882,193
Jackson Park	Jackson Park. Chicago	Independent	$6,458,034
South Shore	South Shore, Chicago	Independent	$1,562,892
Saint Anthony	North Lawndale, Chicago	Independent	$7,677,767
Loretto	Austin, Chicago	Independent	$1,105,550
Northwestern Memorial Hospital	Streeterville, Chicago	Northwestern	$323,697,299
Advocate Illinois Masonic Med Ctr	Lake View, Chicago	Advocate	$153,497,390
Evanston Hospital	Evanston	Endeavor	$84,541,457
Edward Hospital	Naperville	Edward-Elmhurst	$63,179,436

TABLE 2: Independent Hospital vs. System Hospital Capital Investment. Data compiled from Illinois Health Facilities & Services Review Board Annual Hospital Questionnaires.

The uneven geography of capital investment is central to the economic polarization among hospitals. Wealthy hospitals get wealthier as they invest in the technology and infrastructure necessary to provide the most profitable services. Safety net hospitals struggle to sustain essential service lines and often lack the funds to replace equipment or update aging facilities. This process has resulted in a severe wealth gap between hospitals serving wealthier whiter communities and those serving the communities most impacted by health disparities.

Care Deserts

The financial precarity of hospitals in communities of color and the refusal of wealthy health systems to invest in these communities have resulted in a lack of critical services on the South and West Sides.

The closure of obstetrics units in Chicago's Black communities is one urgent example. Figure 3 shows the geography of obstetrics units and obstetrics cuts in Chicagoland since 2015. Obstetrics cuts have been concentrated at hospitals on the South Side and in the South suburbs. The reasoning offered for these service cuts has generally been that the closing obstetrics units are both unprofitable and unsafe due to declining admissions—studies have shown institutions that perform a high volume of a certain procedure have better patient outcomes. This logic has been unevenly applied, however, with hospitals that serve wealthier patient populations largely able to maintain their obstetrics departments.[9]

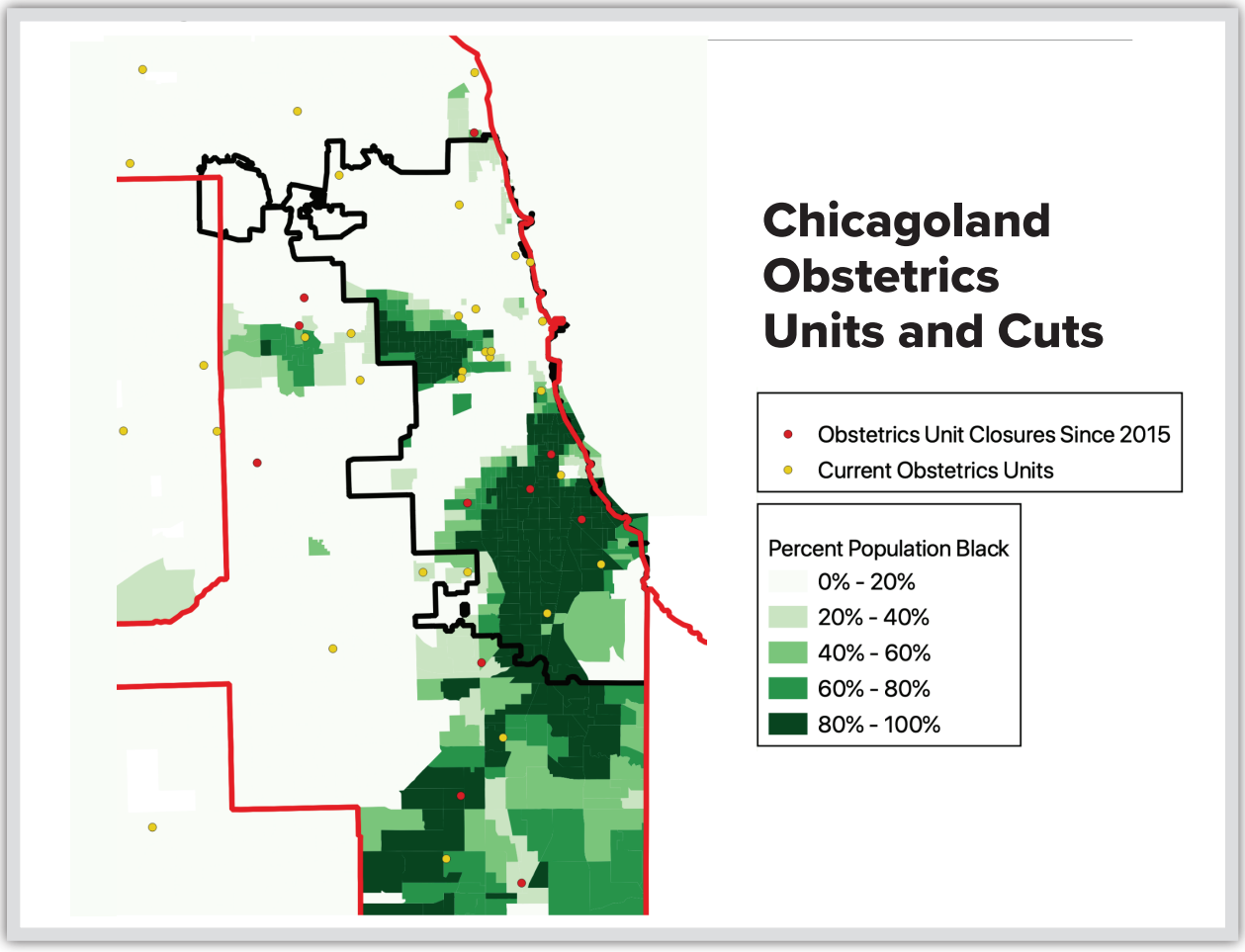

FIGURE 3: Obstetrics units and cuts in Chicagoland

Obstetrics deserts on the South and West Sides are particularly troubling due to the higher rates of maternal and infant mortality in these communities. A large volume of academic literature has shown that lack of access to care throughout the entire timeline of childbirth, from prenatal to postpartum, is a key driver of these disparities.[10]

Additionally, despite higher rates of gun violence on the South and West Sides, these communities lack adequate trauma care. As Figure 4 shows, the only hospital on the South Side that has an adult Level 1 trauma center is the University of Chicago Medical Center.

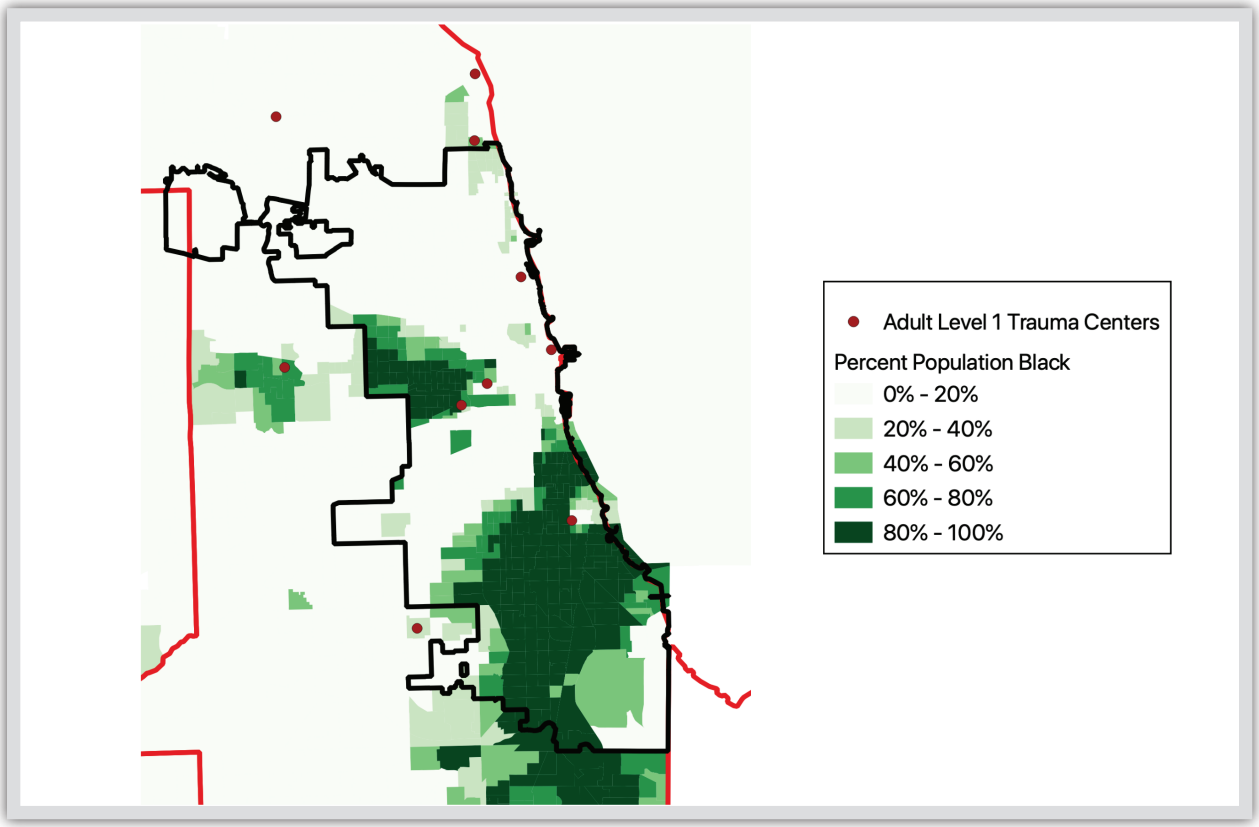

FIGURE 4: Adult Level 1 Trauma Centers in Chicago

The University of Chicago reopened its adult trauma center in 2018 following years of sustained community activism. Prior to this, the South Side had been without a Level 1 trauma center since 1991.[11] Even following the reopening, however, more than 30% of Chicago's Black neighborhoods are at least five miles from an advanced trauma unit.[12] An influential 2013 study showed that traveling more than five miles for trauma care in Chicago significantly increased the risk of death from gunshot wounds.[13]

Decades of uneven investment have created two parallel healthcare delivery systems in Chicagoland, delineated along racial lines. In one system hospitals struggle financially and services are sparse. In the other, health systems accumulate wealth at a staggering pace. The hospital industry as a whole has enough resources to meet the health needs in all our communities, but this will require policy makers to hold health systems accountable and rethink decades of misplaced priorities.

LECRISHA PEARSON
CNA, Mt. Sinai

My name is LeCrisha Pearson and I'm a CNA at Mt. Sinai Hospital, a large safety net facility and trauma center on Chicago's South Side. My mom had been a patient at Mercy Hospital and Medical Center for almost fifteen years when its parent Trinity Health announced its intention to close the facility during the height of the pandemic in Summer 2020. The decision to wind down services at Mercy caused an exodus of providers and staff which left my mom without a primary care physician and cardiologist who were now outside of her insurance network. My mom was fighting cancer at the time, and she was frantic and scared because she had been with these doctors for years. They knew her situation and care needs and she had rapport with them, so the loss hit her hard. Ultimately, a coalition of community groups, unions, and public health advocates was able to block the closure and force Trinity to sell to new owners committed to keeping the facility open, but for my mom the damage was done. She never trusted the medical field and that and went through a series of primary care physicians before she passed from her disease.

PART II
Disinvestment in Workers

Though it has been four years since the onset of COVID-19, and the pandemic's strain on our health systems has long since peaked, the hospital industry is still reporting severe staffing shortages. The Illinois Health and Hospital Association has warned that by next year, Illinois will face a shortfall of 15,000 nurses, and the crisis is not limited to RNs—a recent analysis found that Illinois will have a deficit of 170,000 health care service workers by 2026.[14] Chronic understaffing has contributed to widespread feelings of discontent and burnout among direct care workers, who are consistently thrust into high-stress situations where their unmanageable workloads put patients at risk. In a survey by the American Hospital Association (AHA), 95% of responding nurses reported feeling burnout within the last three years, and over three-quarters cited understaffing and heavy workload as factors.[15] In a recent SEIU survey of Chicagoland hospital workers, 70% of respondents reported understaffing and over 25% of respondents reported unsafe or unmanageable workload.[16] These experiences are leading to an exodus of direct care workers from the industry: In the same AHA survey, 47% of health care workers stated their intent to leave their jobs in the short term.[17]

The ongoing staffing crisis has serious repercussions not just for the wellbeing of direct care workers, but for the health of the patients they care for. A wide body of academic literature has connected low nurse staffing to worse patient outcomes, including higher rates of pneumonia, shock, and urinary tract infections, longer hospital stays, and increased 30-day mortality.[18] Support staff also play a critical role in keeping patients healthy and safe; for instance, cuts to environmental services staff and cleaning hours have been linked to an increased frequency of hospital-acquired infections.[19]

While issues related to understaffing and unsafe workloads have grown worse since the onset of COVID-19, the staffing crisis was not caused by the pandemic. A 2020 study, for instance, found widespread reports of interrupted patient care in hospitals due to understaffing in the months leading up to the pandemic.[20] Instead, the staffing crisis is rooted in the business decisions of profit-driven health systems, which have reduced the time and labor devoted to each patient in order to squeeze productivity out of workers. These business decisions are a response to shifts in public policy that have rewarded hospitals for suppressing labor costs at the expense of worker and patient wellbeing.[21] But there are large differences in how the crisis unfolds at the two ends of the highly inequitable hospital industry, as many of the hospitals serving the most vulnerable communities in Chicagoland lack the resources necessary to attract and retain adequate staff.

JACINTA WOODRING
CNA, Ingalls Memorial Hospital

My name is Jacinta Woodring and I'm a CNA at Ingalls Memorial Hospital in Harvey, Illinois, which is part of University of Chicago Medicine. I work in our Rehabilitation Unit where we help prepare patients to go home. The care we provide is critical in setting them up for success after discharge. That care is compromised though because we are working short staffed about 70% of the time. When workers like me are expected to do the job of 2-3 people, it's impossible to be everywhere we are needed. Call lights don't get answered in a timely manner these days, leaving patients open to fall risks or accidents because they are waiting for assistance to get to the restroom. It is a stressful and exhausting environment to work in. A big reason we work short staffed so often is that there is no incentive for workers to come in on their days off. We work 12-hour shifts and when we get to our off days, we need that time to recuperate. Without any financial incentive to come in and fill in for others who may have called off due to their own exhaustion, it just becomes a terrible cycle. My coworker has raised this with management, but the concern was dismissed. Short staffing is hurting the quality of care for our patients, and something needs to be done. This crisis is unsustainable.

Health Systems Cut Back on Staff

In the late 20th century, health systems adopted business models that sought to limit the staffing resources devoted to each patient. The industry-wide drive to reduce spending on labor was rooted in changes to federal policy that put pressure on health systems to control costs—this included the introduction of the prospective payment system and managed care, and overall reductions to Medicare and Medicaid reimbursement.[22] These developments have been studied for decades by academics, who have clearly demonstrated a link between understaffing, job dissatisfaction, and worse patient outcomes.[23] Intentional skeleton staffing at hospitals has led to a vicious cycle where workers with burdensome workloads feel that they cannot properly meet the needs of their patients and suffer from burnout.

In the decade prior to the pandemic, health systems in Chicagoland were making major cuts to direct care staff. Northwestern Memorial Hospital cut more than 600 full-time equivalent positions (FTEs) from 2010 to 2020, though the hospital experienced an increase in inpatient volume during this period. This represented a 30% decline in FTEs per adjusted occupied bed. In the same period, Ascension Resurrection, located on Chicago's Northwest Side, cut 500 FTEs, resulting in a 33% reduction in FTEs per adjusted occupied bed. Another Ascension hospital, Saint Joseph Medical Center in Joliet, cut their staff nearly in half while experiencing a 30% decline in inpatient volume, resulting in a 33% decline in FTEs per adjusted occupied bed.[24] A New York Times report on Ascension Health found that the health system had boasted in an annual report about reducing employees per occupied bed and cutting their labor costs by $500 million.[25]

Following the pandemic, hospital staffing per occupied bed decreased an average of 3%, despite a 6% increase in the average acuity level of patients.[26] In Illinois, hospital employment dropped 5% and has been slow to recover.[27] Over the last four years, healthcare workers have been quitting their jobs at an unprecedented rate, fed up with high-stress working conditions and inadequate pay.[28] Industry voices have been quick to categorize the ensuing crisis as a worker shortage and have proposed reforms to the "worker pipeline," such as increasing access to education programs.[29] While these proposals should be considered, a policy solely focused on increasing workforce entrants will not be successful in this unprecedented period of workforce exits. To resolve the staffing crisis, health systems will need to listen to the workers they have now, who are demanding that health systems reverse the business practices of the last 30 years and make a transformative investment in workforce.

Safety Net Hospitals Struggle to Maintain Staffing

In the years leading up to COVID-19, the community hospitals serving Chicago's South and West Sides have largely maintained staffing levels in the face of intense financial pressure. Roseland Community Hospital, for instance, experienced a nearly 30% drop in inpatient days from 2010 to 2020 and only marginally reduced staffing levels. St. Bernard Hospital in Englewood saw a 40% reduction in inpatient days in the same period and had a 4.5% reduction in staff.[30] While profit-driven health systems have intentionally decreased staffing levels to expand their margins, independent community hospitals have long struggled to maintain adequate staffing due to severe financial precarity.

In the years leading up to COVID-19, the community hospitals serving Chicago's South and West Sides struggled to maintain staffing levels in the face of intense financial pressure. From 2015 to 2020, Roseland Community Hospital reduced their staff by 45 FTEs, resulting in a 10% reduction in FTEs per adjusted occupied bed. In the same period, Loretto Hospital reduced their staff despite an overall increase in patient volume, resulting in a 7% reduction in FTEs per adjusted occupied bed.[31] These staffing reductions have meant unmanageable increases in workload for workers at the frontlines of caring for Chicagoland's most vulnerable communities, leaving these hospitals and communities woefully unprepared for the pandemic.

During the height of COVID-19, safety net hospitals on the South and West Side struggled to keep up with the pandemic's disproportionate impact on communities of color. For workers, this meant sharp increases in workload as hospitals ran significantly over capacity. During the early pandemic, Saint Anthony Hospital in North Lawndale was running between 120%-140% over ICU capacity, so patients were intubated outside of the ICU unit.[32] During the Omicron wave, Loretto Hospital set up beds in the hallway to manage emergency department overflow. Independent hospitals had little recourse to manage overcapacity, as many hospitals with excess beds, such as Northwestern, were refusing transfers.[33] Lacking the system-level planning capacity or resources of large health systems, independent safety net hospitals had to improvise, but it was the workers who carried the burden. In one example, maintenance workers at Saint Anthony had to make their own sanitizing wipes each morning as the hospital could no longer afford to purchase them.[34]

Tighter labor market conditions in the years following the pandemic have further increased the financial strain on safety net hospitals, as the price of recruiting and maintaining adequate staff has risen. Workers at these hospitals are warning that low wages and dangerously low staffing levels are getting in the way of quality care.[35] Addressing the staffing crisis at safety net hospitals will require financial support dedicated to the workforce, for independent safety hospitals without the resources to navigate an industry-wide labor market transformation in which workers are rightfully demanding higher compensation and better working conditions.

BRENDA GAYDEN

Lead MHS, Loretto

My name is Brenda Gayden and I'm a Lead Mental Health Specialist at Loretto Hospital, a safety net facility located on Chicago's West Side. We have always had an issue with short staffing but since the summer of 2023 it's gotten worse. According to our training we are always supposed to have at least two mental health specialists on the Behavioral Health Unit for safety even if we only have one patient. But management consistently doesn't follow their own policy and only staffs one MHS which puts us in a bad situation where we can't provide the best care for our patients. When we only have one MHS on the floor it's impossible to do elopement rounds without leaving the floor unattended. If something happens with the patients there's no staff person to intervene. Patients also miss out on group therapy and don't get the attention they need from staff due to short staffing. We've had both patients and staff get injured and many staff members who've been injured either quit their jobs or exit the industry altogether. It is crucial that we have adequate staffing, and that management follows their own policies so that we can keep everyone on the floor safe.

Staffing Agencies: The New Normal?

Throughout the pandemic, hospitals have relied on staffing agencies to fill workforce holes in a tight labor market. For example, travel nurses represented around 4% of the nursing workforce before 2020 and now represent close to 10%.[36] Agency fees peaked in 2022 but are still significantly higher than they were prior to COVID-19, with travel nurses receiving nearly twice the compensation of permanent staff.[37]

As staffing agency fees have skyrocketed, this has put additional financial strain on safety net hospitals.[38] Meanwhile, wealthy health systems continue to rely on staffing agencies, paying a premium for temporary workers instead of investing these funds to recruit and retain permanent staff. In 2022, Northwestern Memorial Hospital spent $113 million on contract labor costs for direct patient care compared to zero dollars in 2019. Advocate Illinois Masonic spent close to $20 million on temporary direct care staff in 2022, compared to $1.8 million in 2019. The University of Chicago also paid staffing agencies $20 million in 2022, more than twice what they spent in 2019.[39] And the cost of staffing agencies is more than financial: numerous studies have linked temporary staffing at hospitals to worse patient outcomes.[40]

The current prevalence of staffing agencies is due to a mismatch between what health systems are willing to invest in permanent staff—or what struggling community hospitals can afford to invest—and the labor market value of direct care work at this moment. Health systems view temporary staffing as a hefty but worthwhile short-term cost, hoping to wait out what they view as pandemic-related labor market conditions. But now, more than two years following the pandemic's peak in Illinois, with the system-wide crisis posed by the virus's early waves largely subsided, health systems are still heavily reliant on staffing agencies. A 2023 survey of 3,000 hospitals found that 80% intended to maintain supplemental staffing levels in 2024 and 7.5% intended to increase their use of staffing agencies.[41] For many direct care workers who have left the industry or are considering it, the pandemic represented not just a rough patch at work but a tipping point after years of feeling undervalued and overworked. A long-term resolution to the staffing crisis will require the transformative investment in workforce that these workers are demanding.

DEMANDS FOR AN EQUITABLE HOSPITAL INDUSTRY

Fully Fund Our Hospitals

It is unjust that wealthy health systems refuse to invest in communities of color, while community hospitals on the South and West Sides struggle to keep their doors open. The government must use its role as a major regulator and funder of hospitals to end this racist misallocation of resources. Illinois policymakers have various tools at their disposal that can help ensure funding goes to the hospitals and communities most in need:

1. Reform supplemental Medicaid financing

In addition to reimbursement for services, the state Medicaid program provides hospitals with close to $4 billion in supplemental funding. This program, called the Illinois Hospital Assessment, is an ideal vehicle for addressing racial disparities in hospital financing for multiple reasons:

- The program is financed in part by a tax on hospitals and can thus be a vehicle for redistributing resources from wealthy health systems to community hospitals serving the areas most impacted by health inequities.
- Because the funding is supplemental to payment for health services, it offers the state a high degree of planning capacity that can be used to counteract damaging incentives built into the system of medical reimbursement.

In recent years, the administration of Governor JB Pritzker has made positive changes to the assessment program, boosting funding for Safety Net Hospitals.[42] Even as changes to federal regulations have required the state to introduce more variance into supplemental funding design,

the administration has been an effective and responsible steward of the program, ensuring that it remains an essential lifeline for financially precarious hospitals. However, the program has the potential to move beyond a lifeline and become a redistributive vehicle able to counteract racial redlining in the hospital industry.

2. Ensure grant programs address health disparities and support health care workforce

The state also uses grant programs to provide additional support to safety net hospitals. Any grant programs should adhere to the following guidelines:

- Funding should be targeted at independent safety net hospitals in medically underserved communities, not health systems with large investment funds with track records of disinvestment.
- Funding should be dedicated to expanding access to essential services and should not be used to retract services under the guise of "health care transformation."
- Projects should be geared toward addressing health disparities in vulnerable communities.
- Projects with a workforce component should be prioritized, as safety net hospitals will struggle to address health disparities without adequate staffing and well-compensated workers.

In recent years, the Pritzker Administration has largely followed these principles in designing programs such as the Transformation Fund, the Health Equity and Access Leadership (HEAL) Grants, and a new Medicaid 1115 waiver application that is pending approval by federal regulators. While the latter two have not yet been implemented, the Transformation Fund has already been effective at expanding care access.[43]

Ensure Hospitals are Properly Staffed and Workers are Valued

To ensure hospitals are adequately staffed and that workers have manageable workloads, the state should employ a two-pronged approach that provides support to poorly-resourced hospitals and also holds the industry accountable as a whole:

- Illinois should pass SB 3424, which provides all workers with legal protection to object to unsafe conditions through a competency validation process that allows workers to indicate if they are taking on an assignment despite objection. This will help to ensure that management bears responsibility for the unsafe conditions they have created. In addition, SB3424 extends the prohibition on mandatory overtime, currently in statute but only for registered nurses, to all hospital workers.[44]
- Illinois should mandate minimum staff-to-patient ratios to ensure that health systems make the transformative investment in workforce that is required at this moment.
- Extra funding should be provided to safety net hospitals with the expectation that it is used to invest in workforce.

ENDNOTES

1. The percentage of hospital services in Chicagoland provided by public hospitals is in the low single digits.
2. see David C. Radley et al., "Achieving Racial and Ethnic Equity in U.S. Health Care: A Scorecard of State Performance" (Commonwealth Fund, 2021), available at https://www.commonwealthfund.org/publications/scorecard/2021/nov/achieving-racial-ethnic-equity-us-health-care-state-performance
3. e.g., Alec Soth, "The Great Divide" (The New York Times, September 2020), available at https://www.nytimes.com/interactive/2020/09/05/opinion/inequality-life-expectancy.html
4. Chicago Department of Public Health, "CDPH Data Report: Maternal Morbidity & Mortality in Chicago" (City of Chicago, 2019), available at https://news.wttw.com/sites/default/files/article/file-attachments/CDPH-002_MaternalMortality_Databook_r4c_DIGITAL%20%282%29.pdf
5. CDPH Health Equity Index Committee, "The State of Health for Blacks in Chicago" (City of Chicago, April 2021), available at https://www.chicago.gov/content/dam/city/depts/cdph/CDPH/Healthy%20Chicago/CDPH_BlackHealth7c_DIGITAL.pdf
6. see Chicago City Health Dashboard, available at https://www.cityhealthdashboard.com/il/chicago/city-overview?metric=37&dataRange=city
7. For the purposes of this report, "major health system" means a health system with three or more affiliated acute-care hospitals.
8. Current Illinois Safety Net Hospital Determinations are available at https://www2.illinois.gov/hfs/SiteCollectionDocuments/RY2022SafetyNetHospitalDeterminationFinal.pdf
9. https://www.chicagotribune.com/business/ct-biz-obstetrics-closing-hospitals-labor-delivery-20190903-kgdgsq2ai5a7lmhmyzvago44gi-story.html
10. e.g., Elizabeth A. Howell, "Reducing Disparities in Severe Maternal Morbidity and Mortality" (Clinical Obstetrics and Gynecology, June 2018), available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5915910/
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12. Lisa Schencker, "Black Chicago neighborhoods farther from trauma care than white areas though new U. of C. trauma center helped" (The Chicago Tribune, March 2019), available at https://www.chicagotribune.com/business/ct-biz-university-chicago-trauma-study-20190311-story.html
13. Marie Crandall et al., "Trauma deserts: distance from a trauma center, transport times, and mortality from gunshot wounds in Chicago" (American Journal of Public Health, June 2013), available at https://pubmed.ncbi.nlm.nih.gov/23597339/
14. For hospital industry perspective see A.J. Wilhelmi, "Commentary: Illinois hospital staffing shortages remain a point of pain" (Crain's Chicago Business, January 2024), available at https://www.chicagobusiness.com/crains-forum-physician-retention/hospital-staffing-shortages-remain-pain-point-opinion; for information on the health care labor market analysis see Tanner Bateman et al., "US healthcare labor market" (Mercer, 2021), available at https://www.mercer.com/content/dam/mercer/assets/content-images/north-america/united-states/us-healthcare-news/us-2021-healthcare-labor-market-whitepaper.pdf
15. "2023 Health Care Workforce Scan" (American Hospital Association, 2022), available at https://www.wvha.org/getmedia/7573bffb-a30b-4e35-9001-fec564dd23ae/2023_AHA_Health_Care_Workforce_Scan_FINAL.pdf.aspx
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