income. Health care analysts and providers and virtually all working to improve the nation's well-being recognize that the determinants must be addressed before health systems will be enabled to ensure health equity.[4] There is much dialogue and debate on the upstream causes of health disparities and downstream responses by the health care system.[5]

Currently, working within the health care system may be, in and of itself, a social determinant of health, as the industry's compensation practices inflict damage on the racial/ethnic minority women who are employed. Legal remedies supported by the Equal Pay Act or under Title VII of the Civil Rights Act do not offer clear-cut remedies, as these protect against discrimination on the basis of race or sex.[6] But there should be no need for legal remedies, because the evidence presented is clear. The health care system need not look upstream at external forces for social determinants of health in the ecological context that affects their own employees. Rather, to remediate the causative factors, the health care system must focus within and initiate protocols and the use of metrics that eliminate race as an explicit or implicit variable that continues to disparately impose poverty on female employees of color, their children, and their families. AJPH

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CONFLICTS OF INTEREST

No conflicts of interest.

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In Demand and Undervalued—The Plight of American Healthcare Workers

See also the *AJPH* Special Section on Health Care Workers, pp. 198–210.

When she started her career as a certified phlebotomist, Valery Robinson could not afford to buy health insurance for her family. "It was demoralizing," said Ms. Robinson. "I was working long hours, doing my best to comfort and care for sick and scared patients for minimum wage. I was a health care worker and yet could not afford to buy health insurance for my own children" (personal communication with Mandy Rae Hartz, October 15, 2018).

It is a sad fact that those who contribute the most directly to the welfare of vulnerable populations, such as teachers, day care workers, and social workers, are among the most poorly paid workers in the United States, even when their jobs require a relatively high level of education and training. This is especially true in health care. Ms. Robinson's experience echoes that of many health care workers in the United States who struggle to afford basic necessities for themselves and their families.

VULNERABILITY OF FEMALE HEALTH CARE WORKERS

In this issue of *AJPH*, an article by Himmelstein and Venkataramani (p. 198) on the economic vulnerability of female health care workers in the United States quantifies a worrisome national predicament. In the health care sector, where the wage gap between men and women collides with numerous occupational hazards, the devaluation of women's work puts the nation's health and health care workers at risk.

The nearly 20% of women in the US workforce who dedicate their lives to caring for the most vulnerable people in jobs like nursing, home health, and personal care, are systematically underpaid compared with those male-dominated jobs that require similar levels of skill and training. Himmelstein and Venkataramani found that in 2017, 1.7 million female health care workers and their children in the United States lived below the poverty line. More than 7% lacked health insurance. Many relied on public assistance for health care, food security, and housing.

RAISING THE MINIMUM WAGE

Himmelstein and Venkataramani argue that one solution is to universally adopt a $15 per hour minimum wage. Some jurisdictions are doing just that. For example, in New York State, the minimum wage will rise over time to $15 depending on employer size and location.

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Several other states and municipalities have adopted similar laws. However, such increases are bitterly resisted by employer associations, and are all but impossible in Republican jurisdictions. Even when a higher minimum wage is signed into law, it is likely to be challenged—and delayed—in the courts. After a lengthy and vigorously contested rulemaking, the US Department of Labor extended the $7.25 federal minimum wage to home health care workers in 2013. The rule was challenged by a group of trade associations, struck down by a federal district court judge, but ultimately reinstated by the US Court of Appeals for the District of Columbia (*Home Health Care Association of America v. Weil*). The legal battle only ended in 2016 when the US Supreme Court declined to hear the appeal. The trade associations have vowed to lobby the Trump Administration to eliminate the new regulation.

UNIONIZATION

Unions representing health care workers have been active in the fight for a higher minimum wage. However, collective bargaining—the process of negotiation between an employer and its union-represented employees—provides another avenue to address both the overall devaluation of health care work and the gender and racial disparities between health care workers. Collective bargaining agreements can provide a boost to women regardless of their race or ethnicity. Union contracts standardize wage rates based on experience, promote pay transparency, and include grievance procedures for workers who may have experienced discrimination or been denied the pay they are due. Arbitration based on a union contract can be a swifter and surer remedy than appeal to the courts.[1]

Full-time union health care workers in community and social services occupations earn $221 more per week; personal care and service occupations earn $135 more per week; and health care practitioner and technical occupations earn $128 more per week than their nonunion counterparts.[2]

In addition, collective bargaining agreements go well beyond wage rates with provisions for retirement security, paid sick days, maternity leave, vacations, holidays, and rational promotion based on training, skill, and seniority. Most importantly, union workers are more likely to be covered by employer-provided health insurance and to enjoy greater employer contributions toward that insurance. In fact, union employers pay 78% more per hour worked toward their employees' health coverage.[3]

SAFE WORKING CONDITIONS

The value of one's work is measured not only in terms of wages and other economic benefits, but also in overall working conditions. Here, too, employment standards for health care workers often fall short.

Workers in health care are among those at highest risk for injury from a wide range of workplace hazards, including sharps, chemicals and hazardous drugs, back strain, violence, and stress. Despite the potential to prevent or reduce exposure to these and other hazards, cases of nonfatal occupational illness and injury among health care workers are among the highest of any industry. In 2016, more than half a million health care workers were injured or made sick by their jobs. The injury rate among hospital workers is 80% higher than for the general population; the rate is double for the staff of nursing homes.[4] These numbers do not include the long-term impact of hazardous drugs, sterilants, and disinfectants. A 2011 survey found a widespread lack of training and compliance with safe practices for avoiding toxic exposures.[5]

Under the National Labor Relations Act, working conditions are mandatory subjects of bargaining. In other words, employers are legally compelled to negotiate with union employees over policies and practices that impact the health and safety of workers, including safe staffing practices, limits on the number of overtime hours and extended shifts employers can require health care professionals to work, proactive plans to prevent workplace violence, and improvements to ergonomics, such as patient lifting devices. Such measures do more than protect health care workers: they also protect their patients.

THE ECONOMY

Improving the lot of health care workers is critical to the health of the US economy. Currently employing more than 18 million workers, health care has been the fastest-growing sector of our economy for the past decade. The Bureau of Labor Statistics projects that over the decade beginning in 2016, health care will account for one in every five new jobs.[6]

Valery Robinson, the phlebotomist who started her career earning minimum wage and struggling to meet the needs of her family, is now the president of United Steelworkers Local Union 7600, which represents some 7300 health care workers employed by Kaiser Permanente in Southern California.

"It's not a coincidence that health care workers at Kaiser Permanente were among the first health care workers in the country to form unions and that now our collectively bargained wages and benefits lead the market," said Ms. Robinson (personal communication with Mandy Rae Hartz, October 15, 2018). "Not only are our members among the most well compensated in the sector, our union relationship with Kaiser Permanente gives us a real voice in decisions that impact our wellbeing and the quality care we provide our patients. In short, we are valued." AJPH

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Both authors contributed equally to this editorial.

CONFLICTS OF INTEREST

The authors have no conflicts of interest to disclose.

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