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The government is failing healthcare workers. Unions aren't.

by Chas Walker

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Understaffed, underpaid, and under-protected long before COVID-19 struck, health care workers in the US have had a brutal and traumatic year. Our caregiving workforce – overwhelmingly made up of women, people of color, and immigrants – was on the receiving end of a cascade of political and economic failures set off by the outbreak, but already endemic to life in the United States.

Rhode Island (and, full disclosure, an old employer of mine). When her co-workers at one job began noticing COVID symptoms among residents last spring, the facility's administrator denied it, telling them they did not have the knowledge or expertise to make a diagnosis. Supervisors walked around in N95 masks, but told workers there was no COVID in the building – and no PPE for them.

Dozens of residents died, and countless employees fell ill, including Duquette, whose husband then also got sick. At her other job, a former CNA who had just finished nursing school also brought COVID-19 home from work. It left her physically disabled and emotionally wrecked: the virus killed her 72-year-old mother. Her boss never contacted her, Duquette said, and "she had to do a GoFundMe to bury her mom. Her life has been destroyed and the bosses don't care about her or her family."

"So when we say *'Black Lives Matter,'* it's not just about police kneeling on the necks of our brothers and sisters," added Duquette. "It's about the mothers, the sisters, that are working hard and still cannot pay their bills, that get looked down upon on their job…How is it these bosses are killing their workers and their families, and they are not being held accountable? They're not much better than the police."

With nearly 450,000 people now dead from the virus, the United States leads the world in COVID-related mortality. Residents of long-term care (LTC) facilities have fared the worst: as of January 28, 36% of those who died – 153,159 people – were LTC residents, though they comprise only 1% of the total US population. "We've had big, big losses during

many loved ones."

Like the entire low-wage economy, long-term care runs on a vector-enhancing business model: meagre staffing levels and poverty wages require employees to work several jobs and pick up overtime in order to survive. During the pandemic, bosses continued to pressure workers to come in to work even if a major COVID outbreak was taking place at their other job, and many nursing home chains continued to make what is most appropriately called a killing.

"We find it highly ironic that they call health care workers 'heroes' in one breath, but then don't want to give them hazard pay, don't want to pay them for quarantine, don't want to increase their sick leave…[or] get them the proper equipment that they need to stay safe while they care for other people who are suffering," said Dequasia Canales, a Florida-region Vice President of the 450,000-member multi-state SEIU 1199 United Health Care Workers East (UHE). "Whatever disparities that happened in our health care system and our economy that existed before…this pandemic has indeed exacerbated them."

As COVID ravaged the US, employers – in health care as in meatpacking – faced little pressure from state or federal workplace regulators to improve safety, perpetuating racial disparities of workplace transmission and of community spread in the areas where essential workers live. Katie Murphy, an RN in the COVID ICU at Mass General Brigham in Boston and president of the 23,000-member Massachusetts Nurses' Association (MNA), put it bluntly:

up, as workers organized in their unions and communities to fight for safer conditions and protections on the job. In long-term care, the difference that such organizing made was measurable: a recent report showed that COVID mortality rates in unionized nursing homes in New York State were 30% lower than in non-union facilities.

But these fights over safety had another effect. Unions emerged as a trusted source – in some cases, the *only* trusted source – for information about the new COVID vaccines for frontline workers, who feel that the government and their employers have misled them, exposed them to unnecessary risks, provided them with insufficient protection, and treated them as if they were disposable throughout the pandemic.

"NOBODY ELSE TRIED TO EXPLAIN IT"

Last spring, a Connecticut state official ignited a controversy when she remarked that nursing home workers preferred to wear trash bags instead of PPE. Today, the state's health department has yet to offer vaccine information to workers in Spanish, said Jesse Martin, Vice-President of 1199NE's nursing home division, which he called "a clear sign of how… systemic racism functions within the way the state sees long-term care workers." As for management, Duquette noted "they just come and give you a paper and ask you if you are taking the vaccine. But they don't really care to educate you. It's just the union that will talk to you about the vaccine. Nobody else tried to explain it to you."

Like the rest of the labor movement, 1199NE has been recommending the vaccine to its members. Many are immigrants who wondered if the vaccine had been tested on

current of miscommunication and mismanagement flowing from the highest level. As of January 22, a majority of states had administered less than half of their received doses, and only four had administered more than 60% -- though these numbers are improving.

(In a dystopian twist, many COVID-related government contracts – including the management of vaccine distribution data – were awarded to right-wing billionaire Peter Thiel's company Palantir.)

Then there is the problem of misinformation, much of it stemming from the Trump administration's decision to brand the vaccination effort "Operation Warp Speed," giving the impression that shortcuts would be taken for political expediency. Such questions were prevalent enough that SEIU 1199 UHE addressed them directly in its vaccine FAQ document, noting the extensive development and testing of the vaccines and the independent and science-based approval process they went through, and emphasizing that "nobody—not even the President—can rush it." In Florida, Canales noted the pride she felt in members who have used social media to correct and counter misinformation about the vaccine.

In places where vaccination efforts lagged, some state officials began shifting blame to health care workers themselves. When questioned about the state's low vaccine distribution rate in late December, Ohio Governor Mike DeWine remarked that 60% of workers in long-term care facilities were not taking the vaccine. The announcement set off a frenzy of national media attention, and proclamations from self-appointed experts like

conveyed: "Cash, Breakfast and Firings."

While vaccine hesitancy is real, the numbers cited by DeWine deserve greater scrutiny. For its part, Ohio is not tracking vaccine refusals. The governor based his claim on "anecdotal evidence" from CVS and Walgreens, which have been contracted by the US Department of Health & Human Services (HHS) to run vaccination clinics in LTC facilities in 49 states. The pharmacies provide resident and staff vaccination data to the Centers for Disease Control (CDC), whose website shows as of today that 3.1 million people have received at least 1 vaccine dose in LTC facilities nationwide. Yet for 646,194 of them -- about 1 in every 5 -- the CDC does not know if the recipient was a resident or a staff member.

Nor does the CDC track vaccine refusals, agency spokesperson Kate Grusich confirmed via email. Thus the governor's anecdata -- which has an odor of hearsay to it -- seems better described as an estimate of workers who have not yet been vaccinated. In a round-the-clock industry where many workers rush from one job to the next, the number likely includes people who did not get the chance to be vaccinated if the clinic did not align with their work schedule. It is unclear if vaccination clinics took place on all three shifts, as neither DeWine's office, HHS, nor the CDC responded to inquiries about the clinic schedules.

The two states leading the way in vaccinations, notably, are those who rely on CVS and Walgreens the least: North Dakota, which has a state law restricting the footprint of chain pharmacies, and West Virginia, which was the only state not to enroll in the federal pharmacy partnership program at all.

A QUESTION OF TRUST

It will take more than bribes or threats to get to a higher vaccination rate, both among health care workers and the general population. Experts agree that trust- and relationship-based education and outreach are key to vaccination efforts. What does such an effort look like close-up? One example can be found at Butler Hospital, a 166-bed psychiatric hospital in Providence, RI, which has about 900 employees. The frontline workers are organized nearly wall-to-wall in SEIU 1199NE -- and according to several members of the union's COVID safety team, as of mid-January, the staff's vaccination rate had surpassed 90%.

The union's rank-and-file leadership was pivotal in this achievement. Vaccine clinics were scheduled across all three shifts, but when the hospital announced that employees should make their appointment via work email, the union insisted upon a solution for workers whose jobs – like cleaning patients' rooms or preparing and serving food – do not involve a computer. Besides such logistical fixes, however, was the issue of credibility. After hospital bosses decided in the spring to exclude housekeeping and dietary workers from its distribution of N95 masks, the union took to the streets to demand PPE for all.

Dawn Williams, an RN who has worked at Butler for 6 years and recently became a delegate, attributed much of the success of the vaccination effort to the union's consistent stance for workplace safety and against such discriminatory treatment. "Education needed to be provided to all our staff, not just in their own language but by those they trusted."

from getting the vaccine."

The union proposed the idea of vaccine ambassadors: a group of union members including nurses and pharmacists who were, Williams said, trusted by "those that had no reason to trust administration or the government for that matter." The ambassadors compiled information and answered their coworkers' questions about the vaccine directly. When she later learned how many of her peers had chosen to take the vaccine, Williams said, "I had never been so proud to be part of 1199. That [90%] number represented hope for the future and the safety of my brothers and sisters of 1199."

Without a doubt, such successes are easier in workplaces with an in-house pharmacy and vaccination capacity – and in settings where workers are organized across job classifications. But other lessons are also apparent: high workplace vaccination rates will not be achieved simply by posting a notice above the time clock and parachuting in a vaccinator for a few hours on one shift, or by having the same bosses who mistreat workers serve as the people recommending the vaccine.

Instead, education and outreach – led by trusted health care workers themselves – appears vital to the effort to vaccinate essential workers and the population at large. While she was shopping for groceries recently, Boston ICU nurse Katie Murphy said that a clerk pulled her aside to ask her a few questions about the vaccine and whether she should get it. "I was really glad she asked me," said Murphy. "People stop us on the street all the time. We should harness that trust factor

guide the overall vaccination effort, emphasizing the importance of "education and outreach activities that involve essential workers and our communities deeply and meaningfully," and a distribution plan that prioritizes "communities hardest hit by the virus, including essential workers, people with underlying health conditions and … communities of color" while also recognizing "the impact of structural racism in causing trauma and heightened levels of distrust about vaccination in Black and brown communities."

Across industries, union members have continued to mobilize to demand more from employers and government. They've been conducting member education and outreach about workplace safety and the COVID vaccine, organizing webinars with trusted public health experts, sending out text alerts and videos from union leaders and rank-and-file workers, sharing pictures or videos of themselves getting the vaccine, answering all questions they can, and demanding their members be included in early vaccination rounds. There is no shortage of creative ideas coming from workers: to increase the vaccination capacity, IATSE stagehands have proposed converting shuttered live venues into clinics using union labor.

But health care unions also stress that the vaccine is not a replacement for other safety protections their members have been fighting for and still need. They are re-upping calls for the invocation of the Defense Production Act to ramp up production of PPE and other needed supplies, for universal masking, and more to deal with the current surge and emerging COVID variants – and for policies to address the

Duquette, the Connecticut CNA. "This is the richest country in the world. They need to have people in the White House that represent *us*, who do the job and will tell them: 'This is what my co-workers are facing: foreclosure, eviction notice, gas turned off, electricity turned off.'…We want more than lip service, we want them to fix it."

Exactly one year after the first case of COVID was diagnosed in the United States, it inaugurated a new President. Health care workers are urging a more aggressive, coordinated, and well-funded approach to combat the virus – and the petri dish in which it grew. Whether they are listened to will likely determine if the US can ever flatten the curve, or if it will just continue to flatline.

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NEXT

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