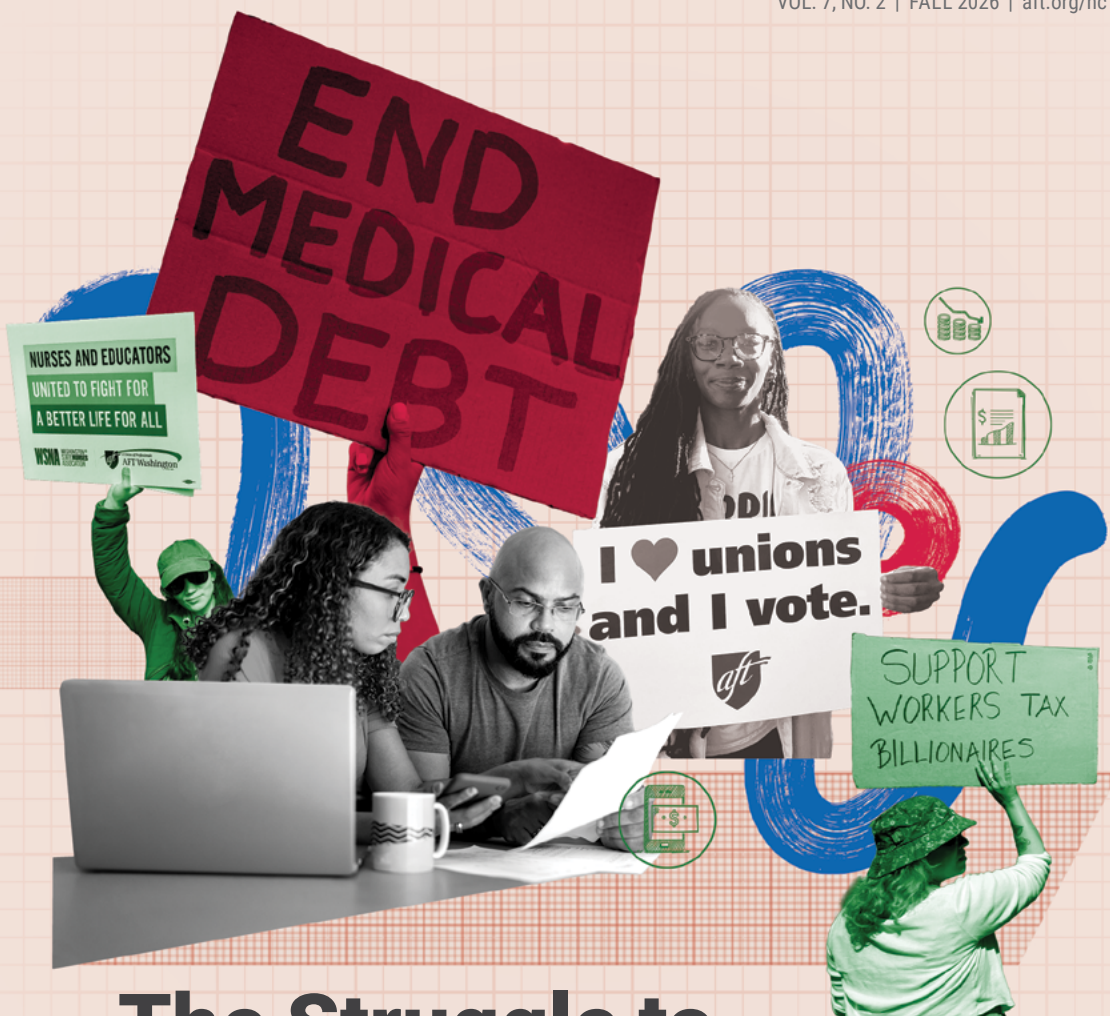


HEALTH CARE

A BIENNIAL JOURNAL ON HEALTH AND COMMUNITY WELL-BEING

VOL. 7, NO. 2 | FALL 2026 | aft.org/hc



The Struggle to Make Ends Meet

In this special issue, we reveal what's behind the affordability crisis—and how we can fix it.

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HEALTH SYSTEM REFORM
IN RURAL AMERICA, P. 46

NURTURING TRUST
AND EQUITY, P. 54



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

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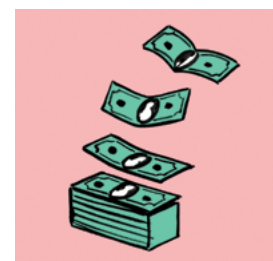
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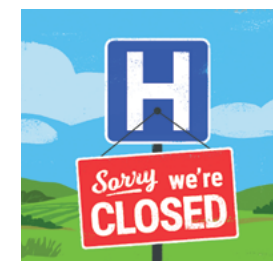


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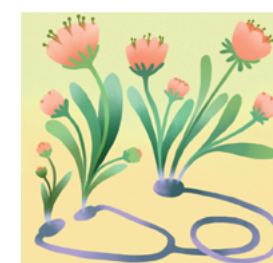
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Building Our Power to Fight for a Better Future

RANDI WEINGARTEN, AFT President

IN THE UNITED STATES, there are now 1,000 billionaires—and the world's first trillionaire—at a time when nearly half of American households—46 percent—don't earn enough to make ends meet.

This *wealth* imbalance—the top 1 percent having as much wealth as the entire bottom 90 percent of Americans combined—has led to a *power* imbalance that affects the lives of everyone in our country. These oligarchs influence policy. They have the power to undo social progress. To sway financial markets, monopolize the media, buy elections, and undermine democracy.

the power and potential of our movement and of the AFT.

The AFT is the fastest-growing union in the AFL-CIO. I am thrilled to announce that, despite everything that's been thrown at us, we have hit a historic milestone: The AFT is 1.875 million members strong!

Half of all nonunion workers in the United States want to join a union, but only 1 in 10 belongs to a union. In the mid-20th century, when 1 in 3 American workers were in a union, we had the largest middle class and the lowest income inequality. That's why, in the long term, growing the union movement is key to

earn enough to make ends meet in 2024. And inflation has soared since then. That means there's not enough to put food on the table, put gas in the tank, and still cover rent. It means constant stress and struggle.

Our members see it every day in the people they teach, heal, and protect. And our members *feel* it.

This winter we surveyed AFT members about the financial issues that keep them up at night, and 7,500 responded. Nearly three-quarters reported living paycheck to paycheck, and more than a third said they were unable to cover all of their monthly bills.

President Donald Trump isn't worried about being able to afford healthcare, housing, or anything else. Since returning to the White House, he has raked in more than \$2.2 billion, through what government watchdogs call unprecedented corruption and self-dealing.

We're not holding our breath for the president to deliver on his promises to lower costs. We're fighting for economic security and to put more money in our

members' pockets—like the one million borrowers we've helped get Public Service Loan Forgiveness relief. Our Fight for Affordability builds on that work, with resources to help navigate medical and credit card debt and other support people are legally entitled to but may not know about (see page 7). And our One Big Bill campaign highlights the devastating consequences of Trump's Big Ugly Bill—like spiking student loan payments—and uses those stories as a basis to fight for much-needed relief (visit go.aft.org/11z to share your story).

We are working with allies in Congress on bold solutions, like increasing the minimum wage to \$25 and passing the Working Americans' Tax Cut Act, which would exempt 104 million lower-income adults from federal taxes—paid for by millionaires paying a fairer share. We're pushing for increased funding for public schools and colleges. We're fighting back against the draconian cuts to Medicaid and to rural hospitals. Millions of children risk going hungry because of the heartless changes to the Supplemental Nutrition Assistance Program in the Big Ugly Bill; we are fighting for every single one of them.

But we need majorities in statehouses and in Congress this year, and ultimately the White House, to secure the foundational changes we seek.

To get a working-class tax cut, to pass living-wage legislation, to get limitless money out of politics, to fix the healthcare system, to strengthen public education, and to restore vital safety net and climate programs, we have to elect people who support working people, leaders with real plans to make life better.

Strengthening public schools and stopping the reckless runaway train that private school vouchers are becoming should not be a partisan issue. Ensuring everyone who works can earn a living wage should not be a political issue. Fighting so everyone has access to high-quality, affordable healthcare should be a human prior-

ity, not one party's priority. Shoring up Social Security to keep seniors out of destitution should have universal support. Addressing the climate crisis that threatens all humanity should *unify* all humanity.

This election will decide whether we are a country governed by the people or ruled by the powerful. A country of opportunity or oligarchy. A country whose people live in freedom or in fear.

That's what's at stake in November 2026. People power can win, but we need to be all in. No one can do everything, but each of us can do something to win in November and achieve the better future we fight for. +

Each of us can do something to win in November and achieve the better future we fight for.

But this is what they don't have: the power of the people.

That's not a mere slogan; it's the potential to work together, to bargain together, to protest together, to vote together, to act together to bring about change. That is

solving America's affordability crisis.

But what do we do now? We've got to win elections. And here's why.

As I said, 46 percent of households—55 percent of households of color—did not



Watch and Share

In her State of the Union speech at the AFT's convention, Randi Weingarten had the delegates cheering as she set forth the AFT's plans to build workers' power and elect candidates who will join us in the fight for a better future for all. While this column offers an excerpt, watch her full speech at go.aft.org/4wn.

PAMELA WOLFE

Working for a Failing System

Three Members' Stories of Medical Debt



In this special issue of *AFT Health Care*, several economists and researchers answer a fundamental question: Why is it so hard to make ends meet? While the full story is complex, there are two simple truths we should all keep in mind. First, wages haven't risen as quickly as they could or should have since the late 1970s; instead, as productivity rose, the gains went primarily to the people who were already ultra-wealthy. Second, a variety of policy choices (like cutting taxes for wealthy people while eliminating insurance subsidies) are forcing working people into debt for basic necessities like healthcare, utilities, medications, and groceries.

The scholars' explanations offer critical insights, but we wanted to call attention to our members and the people they care for: What does our inequitable economy—and the resulting affordability crisis—mean for them? Few people want to talk about being in debt; even though our society is structured to make debt all but impossible to avoid, it seems like anything beyond a mortgage is taboo. We're grateful to the three members featured here for sharing their stories.

—EDITORS

I'M AN ONCOLOGY INFUSION NURSE in a 25-bed critical access hospital in Southeast Alaska. My four-year-old son has a cleft lip and palate, and he needs specialized care that isn't available at my hospital. We do as many telehealth visits as we can with the craniofacial and ear, nose, and throat specialists at Seattle Children's Hospital, but we still have to travel to Seattle sometimes, including for two separate surgeries so far. My son's care team is great and does its best to cluster the in-person appointments, but we still can't avoid staying at least one night in Seattle—and that's the best-case sce-

nario. It doesn't leave a lot of leeway for clinicians who run late, for Seattle traffic, or for any of the challenges of traveling with a young child.

In addition to the few hundred dollars in coinsurance for clinician visits, I spend about \$2,000 for flights, transportation, hotel, and meals each time we travel to Seattle. My health insurance covers two flights a year to Seattle for my son and me, but it doesn't cover any other travel expenses—or airfare for my son's father. Even worse, it can take several months to get reimbursed for the flights. In the meantime, I've got the cost of that airfare sitting on a credit card and drawing interest, unless I can afford to pay it out of pocket.

My son will need additional surgeries as he gets older, so I know that during the years he's going to have surgery I'll need to set a few thousand dollars aside to pay the deductible, in addition to the travel costs. But that's money that I can't spend on other necessities or save against future emergencies.

I see the financial challenges I deal with magnified in my patients' lives. We're in a rural part of Alaska where many patients are insured by some combination of Medicare and Medicaid. My colleagues and I often help patients apply for financial assistance through the hospital and get treatment-related expenses reimbursed by local cancer charities.

Recently, a newer patient brought in a stack of receipts to work on the reimbursement paperwork during her chemotherapy infusion appointment. When I asked if there were other expenses she was struggling with, she told me she couldn't really afford her utilities. Housing and other expenses aren't reimbursable by the cancer charities, so her options were limited. She was paying utilities by credit card, accumulating more debt with every month she couldn't pay the balance. Although charities were filling in some gaps, it wasn't enough. It's extremely disheartening to see her struggle financially, all while dealing with all the fatigue and nausea and vomiting that come with chemotherapy.

—Caitlin, RN
AFT member in Alaska

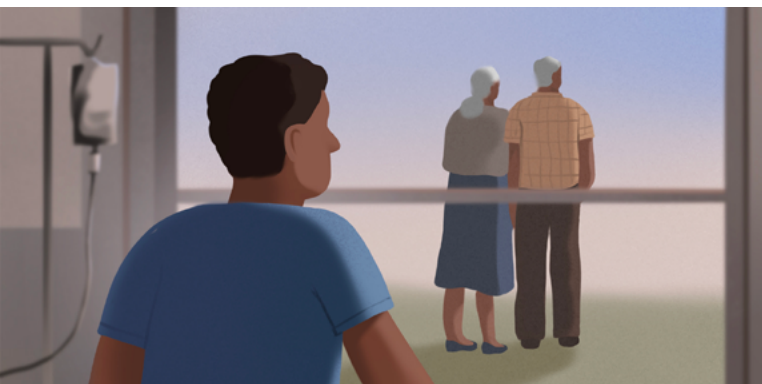
I'M AN ED NURSE, and I've worked for the same Connecticut health system for eight years. Three years ago, my husband and I used IVF treatment to get pregnant. We were on a high-deductible health insurance plan that covered most of the costs, but we still had to put \$12,000 in out-of-pocket costs on a credit card, which we're still paying. My husband had just paid off dental care from six years ago, and immediately we were in debt again.

Meanwhile, my health insurance premiums have

increased significantly and are now up to about \$1,000 a month for my husband, my daughter, and me. But the policies cover less and less, especially since my employer switched providers. We want to expand our family, but with the new insurance, I have only \$10,000 in lifetime IVF coverage for my care team, which is in-network but not in the new policy's "preferred" tier of providers. After two unsuccessful embryo transfers, we put another \$6,000 on my credit card for a third transfer attempt, plus the cost of IVF medications, which aren't covered. We were devastated when that attempt ended with a miscarriage and D&C at nine weeks. Now we're worrying about those bills and whether we can afford to take on even more credit card debt to try with the two embryos we have left. It's all more stress on my health and on our family.



At my hospital, many patients are uninsured because they make too much money for Medicaid but not enough to afford Marketplace insurance—especially now that the Trump administration and Republicans in



Congress refused to extend the subsidies for Marketplace insurance. One patient, a type 2 diabetic in his 50s, has been trying to string out his insulin because he can't afford it. He also can't afford the healthier groceries that would help him manage his blood glucose. He recently came to the ED with blood glucose in the 1,000s and needed to be admitted—but when the registrar came to do the paperwork and the patient found out the ED visit alone was going to cost him at least \$3,000, he decided to leave against medical advice. He didn't have the money, and he didn't want to miss work. I told him that if he went home, he'd probably be too sick to work, but he insisted.

Trying to convince people to stay has become a big part of my job. Our hospital offers payment plans, but sometimes patients can't afford those either. We don't have enough social workers at our hospital to connect patients with assistance or case management. With the increase in demand and limited resources, it's been challeng-

ing to help all our patients get the help they need.

—Kate, RN
AFT member in Connecticut

I AM A CRITICAL CARE NURSE at a large academic medical center in central Ohio. I've seen over and over how inadequate insurance coverage and medical debt impact patients' ability to receive care with dignity in their own homes. One patient was required to receive an IV infusion because her insurance wouldn't pay for a daily oral antibiotic that would have cost thousands of dollars. Instead, she had to have an invasive line placed in her body for several weeks, increasing her risk of infection. And because of the high cost of infusion supplies, she had to be treated at an extended care facility instead of in her home.

Unfortunately, I'm used to caring for patients who have ended up in critical condition because they can't afford care for issues that could have been managed or treated. I

know it's not just part of the job. It's the result of a system that's failing—and it doesn't have to be this way.

Lately, it's been hitting closer to home. Because of a bill that President Trump signed into law in July 2025, my retired parents saw their insurance premiums increase by over \$1,000 per month. They couldn't afford that on their fixed income. They still have Medicare, but dropping their secondary insurance coverage has significantly increased their out-of-pocket expenses for prescriptions and other medical services. It has also affected the decisions they make about their care. Now, they bundle their preventive care services to avoid paying egregious fees, or they delay care altogether. My mom told me she's scared that if something happens, the bills will just pile up, and they could lose their house—so she just doesn't go to the doctor unless she absolutely has to. My dad, who suffers from chronic nosebleeds, is attempting to manage his health at home instead of making an appointment with an otolaryngologist.

I worry about the financial fallout if either of my parents has a serious health issue. They already have to live very frugally, only buying gas to get around and the groceries they need to survive. It's disgusting and really frightening the way things are headed.

—Rick, RN
AFT member in Ohio

The AFT's Fight for Affordability

Resources to Reduce Your Debt

The AFT has long been a champion of student loan borrowers, fighting for debt relief, timely and accurate assistance from loan servicers, and loan forgiveness for healthcare workers and other public servants. Thanks in part to the AFT's advocacy, more than one million public service workers have had over \$78 billion in student debt forgiven—including thousands of AFT members. We have encountered fierce opposition from Republicans and from the Trump administration along the way, but we continue to fight for student borrowers and to offer resources and support to help borrowers navigate complex repayment systems and forgiveness options.

At the same time, workers are being squeezed more than ever by rising costs for basic needs like housing and utilities, as well as healthcare, childcare, and college. In December 2025, the AFT asked members to tell us about how debt and financial stress affected their lives, and more than 7,500 responded. Nearly three-quarters reported living paycheck to paycheck, and more than one-third said they couldn't afford all of their monthly bills. About 35 percent of respondents reported avoiding needed medical care because of the cost, and the financial strain was also taking a toll on members' health: 51 percent said they were losing sleep because of financial stress, and 81 percent reported increased stress levels. About 9 in 10 respondents said they

weren't able to save enough for retirement. And more than 8 in 10 said healthcare costs were a driver of financial distress.

Based on those responses, the AFT launched the Fight for Affordability campaign to help workers care for their families, access healthcare, and retire with dignity. Building on the success of our student debt relief program, we're turning our lens on medical debt. No one should have to choose between paying utility bills and getting the care they need—and we know that when we work together and support each other, we can do so much more than we could ever do alone.

If you're struggling with medical or student loan debt, here are some things you can do right now to take action and restore peace of mind.

- **Learn how to navigate medical debt:** Articles, lessons, and how-to videos will help you figure out how to avoid surprise bills, fight denied insurance claims, negotiate medical bills, and more—all available on the AFT's award-winning platform, Share My Lesson (sharemylesson.com/affordability).
- **Attend a debt clinic:** Sign up for medical debt or student debt clinics, where you can get support to develop a complete picture of your debt situation, talk with experts, and determine next steps to alleviate financial distress (go.aft.org/aftAffordabilityClinic).

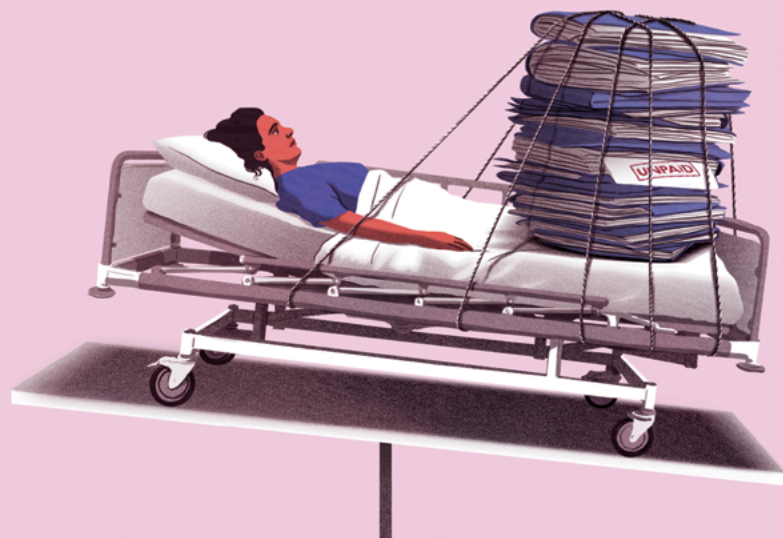


- **Try the debt navigator tool:** Use the AFT's new debt navigator tool to find tailored resources to help you take control of your debt (aft.org/debt-navigator).
- **Explore the AFT's student debt and Public Service Loan Forgiveness (PSLF) resources:** Stay up to date with the latest developments in student loan repayment plans and PSLF policies, learn how to protect your progress, hear members' student debt stories, and share your own (aft.org/pslf).
- **Tell us about your One Big Student Loan Bill:** How have your costs gone up, and what does this mean for you and your family? Your stories will help show policymakers that student loan borrowers need help, now (go.aft.org/11z).

Contact us at affordability@aft.org with any questions you have about your medical or student debt.

—The AFT Affordability Team

Tied Together in Sickness and in Debt



By Barak D. Richman and Frederick F. Wherry

As a nurse working for a nonprofit community hospital, Marcia had seen what medical debt can do. One of her patients, terminally ill with cancer, kept asking to be sent home because she worried about the financial burden on her family if she stayed. Her husband fretted that they could lose the house trying to keep up with the medical bills. Marcia showed up on her days off to check on her patient and called around to secure help with

groceries, school supplies, and utility bills. It was the least she could do for this 40-year-old mother. *This could be any one of us*, she thought.

She didn't realize how soon she would be facing her own mountain of medical debt. It was July 2025 when she convinced her doctor to send her for a colonoscopy screening. She was experiencing bleeding that didn't feel right, though she was being told it wasn't serious.

Marcia did her due diligence when scheduling her appointment, confirming with her insurance company and the clinician, who was located inside an in-network hospital, that the procedure was covered under her plan. But two months later, Marcia received a bill for \$10,097, including an erroneous charge of nearly \$2,000 for sedation and anesthesia that she had declined. The insurance company

had refused to pay, reporting that the provider was out of network.

On her modest income, Marcia could not afford the \$400 monthly payment on the bill—the lowest the health system agreed to offer—on top of what she was paying for medical expenses incurred earlier in the year. Instead of working with Marcia, the hospital threatened to send the debt to collections.

For months, Marcia spent hours on the phone during her days off, looking for resources to help address her debt. She filed two appeals with her insurance; both were denied. She asked the health system to correct the billing error; they gave her the runaround and ultimately refused. And when Marcia sought financial relief from her hospital's employee assistance program, she was told "We don't do medical bills." She worried that she would also lose her house.

Marcia started working as a tech at this very hospital 20 years ago—before a large private health system took over. Back then, her monthly out-of-pocket expense for medical and dental insurance was \$11. Now it's more than 10 times that, in addition to a high deductible. "I might actually have to leave my job," she said. "We recently got raises, but our cost for medical insurance, which is terrible, also increased. That's not a win-win. It's a struggle-struggle." The job that fulfills her calling to care for the sick won't pay her enough to live.

For too many people in this country, going to the doctor means falling into debt. Today, more than 100 million adults have medical debt, and about 1 in 5 believe they will never be able to pay it off.¹ This is a relatively new phenomenon. Until recently, the great gap in our social safety net was evidenced by the rising ranks of the uninsured. In 2010, nearly 18 percent of all nonelderly Americans lacked health insurance. With the passage of the Affordable Care Act (ACA) and other interventions, the uninsurance rate has been cut nearly in half² (though some of those gains are projected to disappear³ because of the cuts made in

President Donald Trump's One Big Beautiful Bill Act).^{*} And the ACA's Medicaid expansion offered real relief to those struggling with healthcare bills. Between 2013 and 2020, states that expanded Medicaid in 2014 had a much greater decrease in average medical debt than states that refused to expand it, where average medical debt barely budged.⁴ Today, gaps in the safety net persist, including provider deserts⁵ and disparities in access to and quality of care.⁶ A prominent illustration of those gaps is the rise and persistence of medical debt across the United States.

The heavy burden of healthcare costs and the specter of medical debt afflict the insured and uninsured alike. Approximately 23 percent of US working-age adults—nearly 1 in 4—are considered "underinsured,"⁷ which means that while they have health insurance for the full year, their out-of-pocket medical expenses pose significant strain on both finances and health.

More than 100 million adults have medical debt, and 1 in 5 believe they will never be able to pay it off.

The spread of underinsurance is just one example of how too many workers are not protected from the risks of healthcare costs. Health insurance premiums are going up while coverage is going down. Deductibles and copayments are also going up, which means even the insured must pay hefty prices

*For more on the effects of Trump's healthcare policies, see "What Donald Trump's Second Presidency Has Meant for Health" in the Spring 2026 issue of *AFT Health Care*: go.aft.org/tpj.

to access care.⁸ Doctors who used to be in-network are now out,⁹ and the idea of finding a new provider is overwhelming. And patients are constantly stretching the limits of the care they receive. More than half of Black households and 4 out of 10 white households are cutting their pills in half or skipping doses, substituting over-the-counter drugs for their prescriptions, or simply not taking what their doctor prescribed because of cost.¹⁰

Healthcare costs are high, health outcomes are poor, and medical debt is rising because of the policies we've chosen.

These structural problems express themselves with brutal specificity when illness strikes. Most medical debt is triggered by a one-time or short-term medical expense,¹¹ and even small, unexpected medical costs have long-term financial consequences: Garnishments can empty bank accounts and effectively suppress wages; credit-damaging collections and court judgments make it harder to rent an apartment or get approved for a mortgage; and court and interest charges cause debt to grow. A one-time illness can place a lasting burden on building and maintaining wealth.¹²

Overcoming a debt crisis forces difficult choices, often Hobson's choices such as either receiving medically needed care along with painful debt obligations or forgoing care and risking tragedy. About 2 in 5 Americans report that they ignore symptoms, skip scheduled appointments, and grind on.¹³ Many also report more serious consequences like skipping payments on other bills, delaying

college or buying a home, or changing their housing situation as a result of their debt. And medical debt itself contributes to poor health. More than half of underinsured adults avoid necessary medical care because of cost, and 1 in 7 adults with healthcare debt say they have been denied care by a "hospital, physician's office, or other medical or dental provider" due to unpaid bills.¹⁴ But health problems often do not resolve themselves, and by the time many patients get the care they need, they are struggling with graver conditions and steeper bills.¹⁵ This also impacts clinicians, as they bear the moral distress and injury of caring for patients who are sicker, have higher stress levels, and fear falling deeper into debt.¹⁶

These are not just people who deny the value of preventive medical care. Many work at hospitals, as Marcia does. The health sector simply is not working for many Americans, including for those who tirelessly and devotedly work within it.

How Did This Happen?

No one entity is solely responsible for the injustices that flow from the nation's health sector. Policymakers, hospitals, insurers, pharmaceutical companies, and many others who participate in the roughly \$5.5 trillion healthcare industry—even some clinicians—deserve some blame for lacking foresight and compassion for the millions of Americans who are left with little recourse to manage their growing medical debt.

One thing that is clear is that the nation is spending healthcare dollars profligately while failing both to protect those vulnerable to illness and to promote our collective well-being. Data collected by the Centers for Medicare and Medicaid Services show that healthcare expenditures have been rising dramatically for generations. In 1980, they were \$804.4 billion (in constant 2024 dollars) and roughly \$3,491 per capita. They grew to \$2.29 trillion in 2000 (also in constant 2024 dollars) and roughly \$8,100 per capita, and then to \$4.97 trillion or over \$14,931 per capita in 2020. We're now well

over \$5 trillion. These numbers capture how much was spent on healthcare and on related activities such as insurance administration, medical research, and public health.¹⁷

This is far more than what comparable countries pay for healthcare. The US expenditure per capita is about 50 percent higher than the expenditure in Switzerland or Germany, and we spend more than twice as much per capita as Denmark, the United Kingdom, or Canada.¹⁸ But we are not spending our dollars wisely. Compared to other wealthy nations, life expectancy in the United States is lower, avoidable deaths are higher, and US patients are most likely to skip needed care because of cost.¹⁹ Plus, the prevalence of heart disease, diabetes, and lung disease is significantly higher in the United States than throughout Europe.²⁰

Policies That Neglect Common Sense

The reason our healthcare costs are so high, and the reason we continue to suffer from both poor health outcomes and rising medical debt, is because of the policies we have chosen. We have never prioritized addressing the day-to-day struggles of raising a family and maintaining daily well-being. Instead of providing the basics, such as access to primary care, a reliable supply of necessary therapeutics, and support for elder care and chronic conditions (or even helping families with the stressors of obtaining childcare, housing, and healthy food), we have a system that seizes boatloads of money from workers' monthly paychecks and offers a feeding frenzy for some of the nation's most ravenous corporate interests—insurers, health systems, pharmaceutical companies, and the many intermediaries. Thus, we find ourselves mired in a complex, profit-seeking system in which the word "choice" obscures more than it reveals. We rely on employers to provide health insurance to working Americans (largely ignoring the hardships of those who can't find a job that offers insurance), but employers rarely ask those workers what

kind of plan they want. Workers are often left with few choices and with plans that eat away at their wages. Over the past three decades, health insurance premiums have increased about three times faster than earnings.²¹

Our current medical debt crisis is therefore a simple consequence of math, a juxtaposition of wages that rise gradually while healthcare costs rise steeply, and it is no surprise who is hurt most. According to a KFF survey in 2022, 41 percent of adults in the United States had medical or dental debt, and that number went up to 57 percent for adults with household incomes under \$40,000. Even among adults with household incomes above \$90,000, 26 percent reported medical or dental debt.²² And while more than 80 percent of the uninsured said in an April 2026 KFF poll that it was difficult to afford healthcare costs, 42 percent of those with insurance said the same. It is no wonder that more Americans are worried about healthcare costs than about the price of gas, groceries, or rent.²³

Failures of Accountability

Our health system also makes it impossible for patients to conserve their limited health-





care dollars. Patients cannot shop for affordable care because few providers disclose their prices, because insurers add complexity and institute bureaucratic controls over coverage rather than guiding patients to the care they need, and because policies designed to protect low-income patients are often not followed. Hospitals have largely failed to comply with price transparency requirements that have been in effect for over five years, making price comparisons impossible.²⁴ A recent study revealed that the price of a procedure in a single hospital may be more than 10 times higher for one patient than for another, and between hospitals that variation jumps to as much as 31 times; for example, at Spring View Hospital in Lebanon, Kentucky, the minimum insured negotiated price for an appendectomy is \$1,574, while the maximum insured negotiated price is \$35,908.²⁵ Patients routinely are befuddled with the bills they receive, even after having asked for clear quotes before receiving care.

Billing errors and overcharges are also commonplace in hospital invoices. One study found that 45 percent of nonprofit hospital organizations were regularly sending bills to patients with incomes that would have qualified them for what the hospitals call “charity care.”²⁶ (Although hospitals are obligated to publicize charity care policies, they can structure those policies however they’d like, and the

charity required of them is very minimal; most analyses suggest that charity care constitutes less than 1.4 percent of hospital operating expenses.²⁷) This matters not only for those who meet the income qualifications but also for their children and other loved ones who are called on to help them.

We ask too much of patients, expecting them to act as accountants at precisely the moment they suffer from illness. And we have little sympathy when bills and debt catch them by surprise.

Making a Bad Problem Worse

Our country has compounded these problems by treating those suffering from medical debt as if they have freely chosen their hardships. We blame patients for mismanaging their finances, spending too much for an unnecessary procedure, or failing to shop for affordable care. We focus on what patients chose, paying little regard to how hospitals, insurers, and others ensnare ordinary individuals in a system of hidden prices, billing complexity, and escalating costs—and ignoring the obvious fact that as you’re loaded into an ambulance after an accident or given a cancer diagnosis, researching affordable care may not be possible.

Few patients understand the healthcare prices they confront or the bills they ultimately receive, and many are then further victimized

by the court system and the providers that choose to use it. The last 25 years have seen a growing tendency by hospitals to use aggressive legal actions to collect medical debt. One study found that hospital lawsuits over unpaid medical bills increased by 37 percent in Wisconsin from 2001 to 2018.²⁸ An examination of medical debt collections in North Carolina found similar results, including that interest charges and court fees increased patients’ medical debt burden by more than 35 percent.²⁹ And a recent study examining Virginia court records found that medical debt collection lawsuits constituted more than one-fourth of all of the state’s debt collection actions from 2010 to 2024.³⁰ All three studies also reported that a relatively small subset of hospitals were responsible for a vast majority of the lawsuits.

As if illness and its financial consequences were not traumatic enough, many patients must then suffer the stress of receiving court summonses and legal threats. It is easy to lose trust in a health system that is insensitive to the real physical and emotional toll that patients suffer when hauled into court. More than half of adults with medical debt say they have made what they feel to be a difficult sacrifice to pay down their debt, causing them to feel as if they could not provide a good life for their families or despair that they will never extricate themselves from debt.³¹ Harassment from debt collectors and adverse impacts on credit scores lead to additional financial problems, such as difficulty buying vehicles needed for work or buying or renting a home.

Court actions to collect medical debt harm patients in other material ways as well. Once patients are sued for their debt, they then are subject to court fees, attorneys’ fees, and interest charges. The North Carolina study showed that those fees increased their debt by more than one-third; some families owed more than \$10,000 in interest alone.³²

Hospitals, courts, and other public institutions that pledge to protect public health and safety need to confront their practices that

harm their patients and the health of their communities.

What Should We Do Now?

Julia works as an ICU nurse at a rural hospital in Washington state. Over the years, the hospital administration’s attempts to cut health insurance costs have had the opposite result for employees, who have dealt with repeated changes to insurance plans, sudden disruptions in care, and lots of shocking medical bills. Seeing her coworkers and friends dealing with these problems spurred Julia to take action. “That’s when I started getting involved with the union,” she said.

Hospitals, insurers, and others ensnare individuals with hidden prices, billing complexity, and escalating costs.

As a union leader, Julia has heard about many of her colleagues’ hardships, but even she was shocked to learn that some of the CNAs and RNs at a nearby hospital were sent to collections by their employer and were seeing their wages garnished to pay for recent ER visits. Even worse, these members hadn’t let their bills go unpaid—they never received bills at all, or any kind of itemized accounting of the charges. The first they learned of any supposed debt was from the collection agency.

“It’s mind-boggling,” Julia said. “While you are working your tail off, the same company you’re working for sends you to collections and takes money from your paycheck before you even know what you’re supposed to owe. In the meantime, it hits your credit, and that has impacts that can last for years.”

Protecting healthcare workers against the threat of medical debt is a top priority for Julia's union. They have fought to restore in-network status to preferred physicians and eventually negotiated contract language requiring the hospital to give the union advance notice of plan or benefit changes to protect members from expensive surprises. "We have to be vigilant," Julia said, "but we know that when we fight back together, we can win."

The kinds of benefit changes Julia and her coworkers experienced are far from unique—and for too many employers, they go unchallenged. But as Julia has learned in her years of union activism, collective action can help to turn the tide.

In recent years, physicians are also seeing merit in forming unions to combat dominant hospital employers. From 2000 to 2022, physicians filed paperwork to form unions at a rate of about two petitions per year. In 2023 and 2024, the rate spiked to more than 16 per year. Physicians cite the same reasons for unionizing* as Julia—protecting the integrity of healthcare delivery, redressing unsafe working conditions, and demanding a voice against increasingly corporatized medicine.³³ There is a growing sense across all categories of healthcare workers that the nation's health system isn't working the way it should for anyone.

Rethinking Our Choices

Since the medical debt problem has grown so severe, some policymakers have started listening. In 2025, the Virginia state legislature passed the Medical Debt Protection Act, which limits interest collection on medical debt, mandates a 90-day interest-free grace period, and prohibits extraordinary actions like home foreclosures and wage garnishments for certain individuals.³⁴ Other states and the District of Columbia have also

*For a detailed look at why one group of physicians decided to unionize, see "Do No Harm" in the Spring 2023 issue of *AFT Health Care*: go.aft.org/itn.

worked to eliminate or prevent the injustices of medical debt. Some, like Pennsylvania, have used state healthcare funds to cancel medical debt owed by residents. Others, including Arizona, Colorado, Illinois, Minnesota, and Oregon, have taken measures to cap interest rates for medical debt, stop creditors from garnishing wages or putting liens on homes, or prevent medical debt from hurting credit ratings.³⁵

These policies are commendable, but much more is needed.

Hospitals and other public institutions need to confront the practices that harm their patients and communities.

Certainly, the causes of medical debt need to be addressed and not just its worst outcomes. At the very least, that means medical bills must be accurate, comprehensible, and issued alongside efforts to ensure that those eligible for low- or no-cost care receive the assistance hospitals promise. It also means healthcare prices should be transparent, and patients should have both some opportunity to shop for affordable care and the agency to understand the financial burdens they assume.

Employers should also take the burdens of medical bills seriously. Because employers play an active role in constructing employee health benefits, they can negotiate on behalf of their employees for accessible physician networks, avoid predatory providers, and offer insurance that genuinely protects from

financial ruin. For example, when the human resources team constructs a provider network for employees, they should be aware of which hospitals are suing patients and lean on those providers to cease those litigation activities. It's also important that employers resist the many intermediaries and monopolies in the health sector, invest genuine effort to deliver value to workers, and direct employees to high-value providers (that, among other things, will not burden their patients with medical debt collections). In truth, these efforts are not discretionary—the law requires employers to put in this work on behalf of their employees.³⁶ Unions can both hold employers directly accountable and demand from policymakers that the purchasers of healthcare are held accountable to those who ultimately need it.

Hospitals and other community institutions—especially those that receive tax exemptions, government subsidies, and other favors from the taxpayer—must also take their responsibilities to their community seriously and recognize the harm they inflict when they sue their patients. This is all the more true for

hospitals that sue the very people who deliver lifesaving care and help them achieve their missions. It is time for hospitals to stop suing patients, and legislative changes can make it so—if only we, the voters, demand it.

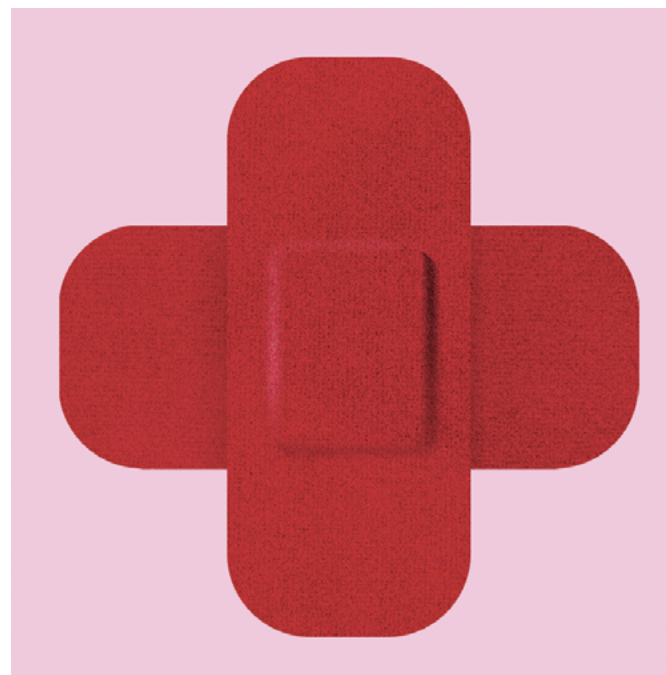
Our collective choices can also make healthcare more affordable. The nation will continue to suffocate from healthcare costs so long as we continue to spend the most but get the least among all our peer nations. Changing the course of our healthcare system—shifting our focus toward more primary care and less hospital care, expanding preventive and high-value services and becoming less tethered to a reactive system designed to respond to severe illness, and making real advances toward accessible and affordable care for all—will require a nationwide effort, with a reckoning from every stakeholder in the health sector, but it is needed and ultimately will benefit everyone.

Sadly, it will become harder before it gets easier. The recent expiration of the ACA subsidies and imminent cuts in Medicaid will make more Americans newly vulnerable to the financial consequences of illness.

Now is the time to demand a compassionate health sector, one that refuses to condone lawsuits against patients and other punitive actions against those struggling with illness. It is also the time to give healthcare workers the respect they deserve and to support unionization efforts that give them the strong voice they need to build a system that truly cares for people. And it's a time to think deeply about how we can build a healthcare system that serves the daily needs of Americans without the constant threat of financial distress.

There's no time to lose. ✚

For the endnotes, see aft.org/hc/fall2026/richman_wherry.



Wages, Inequality, and the Roots of America's Affordability Crisis



By Heidi Shierholz and Josh Bivens

Outside of a crisis or recession, Americans' perceptions of how the country and economy are being managed have never been so negative. Many have attributed this voter unhappiness to a crisis of "affordability."

It is objectively true that it is too hard for most American families to afford a secure and dignified life. But the word "affordability" leads too many people—including policymakers—to fixate on *prices*. Affordability is not just about prices; instead, it's the outcome of a race between incomes and prices.

Heidi Shierholz, PhD, is the president of the Economic Policy Institute (EPI). Josh Bivens, PhD, is EPI's chief economist.

This is not just economists quibbling. Focusing on prices will lead policymakers to ignore far too much of the useful playing field when thinking about what changes could make life better for working families.

In this article, we make the following arguments:

- Far too many families are unable to afford a decent economic life.
- The primary cause is a large increase in income and wage inequality, with incomes and wages for the vast majority of families lagging far behind what they could and should be.
- This rise in inequality was caused by increasingly unequal "market" incomes

(e.g., wages and salaries, returns on investments), while changes in taxes or transfers (e.g., Social Security, Medicare, unemployment insurance) slightly *dampened* the rise of income inequality.

- The large rise in income inequality was driven by *intentional* policy changes that affected typical workers' leverage and bargaining power in the labor market—and that means they can be reversed.
- In capitalist economies (like ours), labor markets are inherently tilted toward employers—but historically and globally, broadly shared prosperity has only been achieved when policies that intentionally support workers (like strong unions, adequate minimum wages, and full employment mandates) have provided a countervailing force against employers' power in labor markets.
- Much of the post-1979 period in the United States saw an assault on worker-friendly policies, and this led directly to the rise in inequality and to weak income growth for working families.

Americans' Economic Dissatisfaction Has Real Roots

The US economy is the richest in the world, yet the gap between what it could deliver to working families versus what it actually delivers is mad-

Affordability is not just about prices; it's the outcome of a race between incomes and prices.

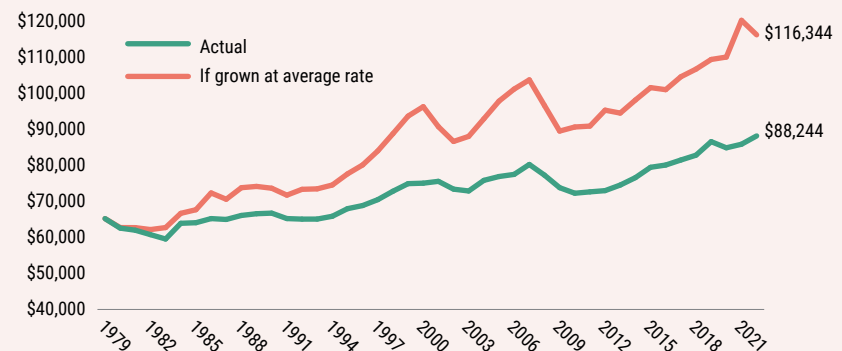
dening. This gap can be measured with some precision. Figure A shows inflation-adjusted household income for the middle-fifth of US families between 1979 and 2022, as well as what this growth could have been had it simply grown as fast as average incomes did in this period.

This gap is driven by inequality. Average incomes can only rise faster than incomes at the middle if some groups—the ultra-rich in this case—see strongly above-average growth. This gap between average growth and growth experienced by the middle reached staggering levels by 2022 (the most recent data from the Congressional Budget Office). In that year, inequality's rise since 1979 deprived middle-income families of an average of \$28,100. Life for these families would be far more affordable today if they had this money coming in each year. And that's well

FIGURE A

The Growth Gap Suppresses Income for Middle-Class Families

Growth in Market Incomes for Non-Elderly Households in the Middle Fifth of the Income Distribution, Actual and If They Had Grown at the Average Rate, 1979–2022



Note: Authors' analysis using data from the Congressional Budget Office (CBO) on the distribution of household income.¹ We constructed a measure of average income of non-elderly-headed households from information provided in the source data. Elderly households receive the large majority of their income from nonmarket sources, so developments within the market economy that raised inequality would affect them less.

within our grasp. Average income growth is by definition attainable. All that's needed are policies that ensure income growth is broadly shared, instead of policies that cause staggeringly fast income growth among the top 1 percent and much slower income growth for working people.

Figure B shows this inequality another way—charting average annual growth rates for the 1979–2022 period for a number of groups ranked by their position in the income distribution. The strikingly bad news from this figure is that only household groups above the 90th percentile saw income growth that matched or exceeded average income growth. How can more than 90 percent of households be below average when it comes to income growth? This is possible because the top 5 percent—and especially the top 1 percent—saw astoundingly fast growth over this period.

For any given average growth rate, faster growth at the top of the scale must be matched by slower growth at the middle and/or bottom. It

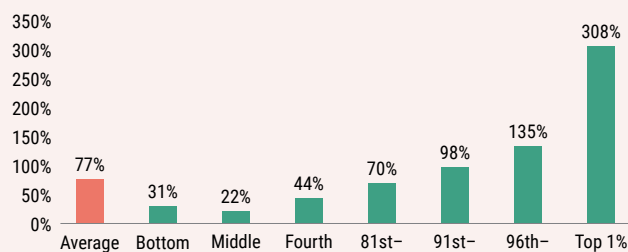
is this zero-sum dynamic of inequality, not anything to do with prices, that has been the crushing drag on regular Americans trying to afford a better life over time.

Staggering Inequality Is a Choice

This growth in inequality has been driven by the rules governing markets—rules our elected leaders determine—not by taxes or transfers. Figure A showed the staggering \$28,100 gap in market (pre-tax and transfer) income between what families in the middle-fifth actually made

FIGURE B
The Vast Majority of US Households Saw Below-Average Income Growth

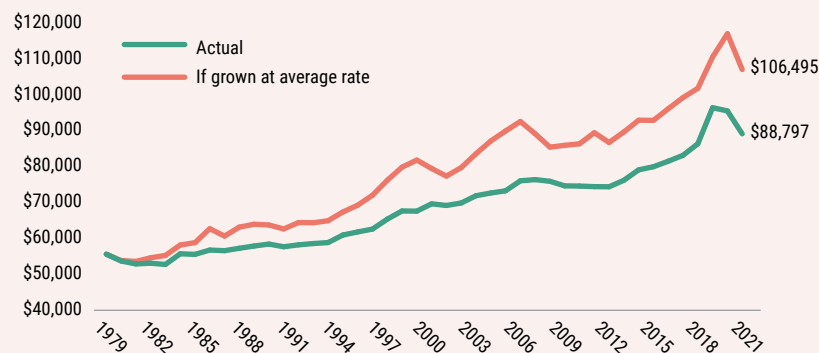
Cumulative Growth in Real Household Income by Income Group, 1979–2022



Note: Authors' analysis using data from the CBO on the distribution of household income.² For this chart, we used the overall population, not just non-elderly.

FIGURE C
Federal Taxes and Transfers Shrink But Don't Eliminate the Gap

Growth in Post-Tax and Post-Transfer Incomes for Non-Elderly Households in the Middle-Fifth, Actual and If They Had Grown at the Average Rate, 1979–2022



Note: Authors' analysis using data from the CBO on the distribution of household income.³ We constructed a measure of average income of non-elderly-headed households from information provided in the source data.

in 2022 versus what they could have made had inequality not risen. Figure C shows how large this gap is after the federal government gets involved on the tax and transfer side of the equation.

Taxes obviously reduce incomes, but transfers (social insurance like Social Security and income support payments like unemployment insurance) raise incomes. For the middle-fifth of US households, this effect is largely a wash—their current income levels in Figures A and C are very similar. But because the United States still has a progressive federal tax system (though not as progressive as we would like), the rise of inequality in this post-tax and transfer data is slightly muted—i.e., federal taxes and transfers shrink the gap somewhat. By 2022, the annual gap after accounting for federal taxes and transfers is \$17,698—still a sum of money that would be transformative for American families.

Essentially, federal taxes and transfers undid roughly one-third of the rise in income inequality, allowing rich households to pocket roughly two-thirds of their gains.*

*Since this analysis goes through 2022, it does not include the tax or benefits cuts (including to Medicaid and the Supplemental Nutrition Assistance Program) in the One Big Beautiful Bill Act that President Trump signed into law in July 2025. These will further increase inequality.

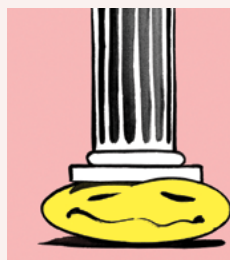
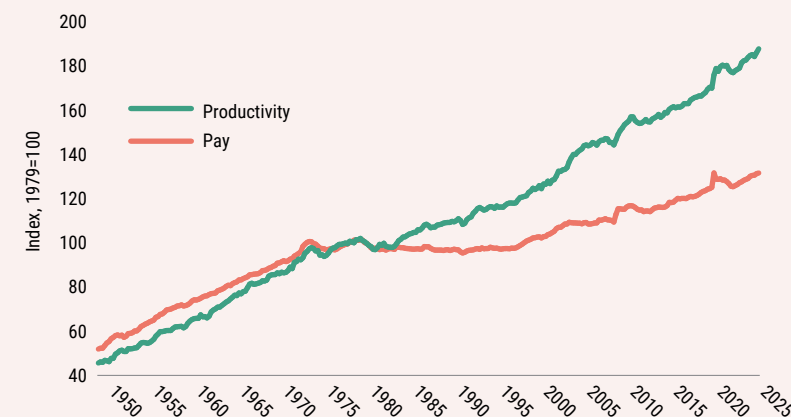
The growth in inequality has been driven by the rules governing markets—rules our elected leaders determine.

This rise in inequality was overwhelmingly driven by an intentional, multipronged policy campaign to suppress wages that was undertaken by shareholders, other capital owners, and corporate executives, with policymakers greasing the skids along the way.⁴ The primacy of wage suppression can be seen in Figure D, which compares the economy's *potential* to pay higher wages and incomes with the actual hourly pay of typical workers in the United States.

We measure the economy's potential to pay higher wages by *productivity*, which is the output and income generated in the economy in an hour of work on average. And we define *typical workers' pay* as the wages and benefits of workers in production and nonsupervi-

FIGURE D
The Root of the Pay-Productivity Gap Is Wage Suppression

Typical Workers' Hourly Pay and Economy-Wide Productivity, 1948–2025



Note: For a full accounting of methods and data, see epi.org/productivity-pay-gap. For this chart, we recentered the indices on 1979. Both lines are adjusted for inflation.



sory positions, a group that constitutes over 80 percent of the economy's private-sector workforce, excluding higher-wage managers and executives. As you see in the figure, in the three decades after World War II, productivity and pay mostly moved roughly in tandem, with typical workers' pay rising 83 percent as fast as productivity. After 1979, these lines diverge sharply, with workers' pay rising only about 43 percent as fast as productivity.

If typical workers' pay had risen in line with productivity growth in the years since 1979, their hourly pay would be 43 percent higher today. For a full-time, full-year worker making the median wage, this would constitute annual wages that are almost \$23,000 higher.⁵ Where did that \$23,000 go? Instead of paying workers more as their productivity rose, corporate executives, other already highly paid professionals, and shareholders captured those gains for themselves.

This growing gap between what shows up in typical workers' paychecks and benefits versus the overall income being generated in the economy is the root story of American inequality and of today's affordability crisis.

This pay-productivity gap can be decomposed into two parts: the portion driven by rising inequality in "labor" income (income earned from work), and the portion driven by a shift from labor income to "capital" income (income from investments, like when a stock

increases in value). Growing inequality within labor incomes—earnings growing much faster among high-paying jobs than among middle- and low-paying jobs—accounts for almost 80 percent of the gap. The remaining 20 percent is accounted for by a shift from labor income to capital income.⁶ Below we say a bit more about each of these.

Rising Inequality of Labor Incomes

The larger factor in the rise of overall income inequality is the growing inequality within labor incomes. This often surprises people, who assume the story of rising inequality is mostly one of the *profits* of rich corporations rising while most of their workers are left behind. It's true that most workers in these corporations do not benefit, but the powerful employees who do prosper—CEOs and other executives—receive astronomical salaries that are classified as labor income in economic data, and these inflated executive salaries do cut into corporate profits.

In addition, below the stratospheric level of corporate managers at large companies, there is a stratum of workers in medicine, legal services, and finance who command huge salaries. It's not a large group of people, but the rise in their pay has been extreme. Figure E highlights this radical inequality within labor incomes, showing annual earnings of various wage groupings. (To keep the figure

legible, pre-1979 data are not shown.) Prior to 1979, wage growth among very high wage workers—those in the top 10 percent, the top 1 percent, and the top 0.1 percent—was roughly in line with wage growth for the vast majority (i.e., for the bottom 90 percent). But between 1979 and 2023, cumulative growth in average annual earnings for the bottom 90 percent of workers was 44 percent, compared with 133 percent for the top 1 percent. For the top 0.1 percent, this growth was 354 percent—so high it doesn't fit in the figure.

Given that labor income remains the large majority of all income generated in the economy, this huge rise in inequality within labor incomes is a key driver of the economy-wide march to greater inequality. Workers at the top of the wage scale were largely able to insulate themselves from the campaign of wage suppression launched by corporate owners. Of course, some of them were active participants in this campaign and got a significant cut of its benefits (think CEOs and lawyers for union-busting law firms). But the vast majority of workers (roughly 90 percent, as we see in Figure B) were on the losing side of this wage suppression campaign and found their wages falling far behind the economy's potential to deliver strong and sustained wage growth.

In some ways, the influence of rising inequality within labor incomes might be underestimated. For decades, US tax policy has levied lower tax rates on capital income than labor income, and a great deal of capital gains escapes taxation entirely due to loopholes.

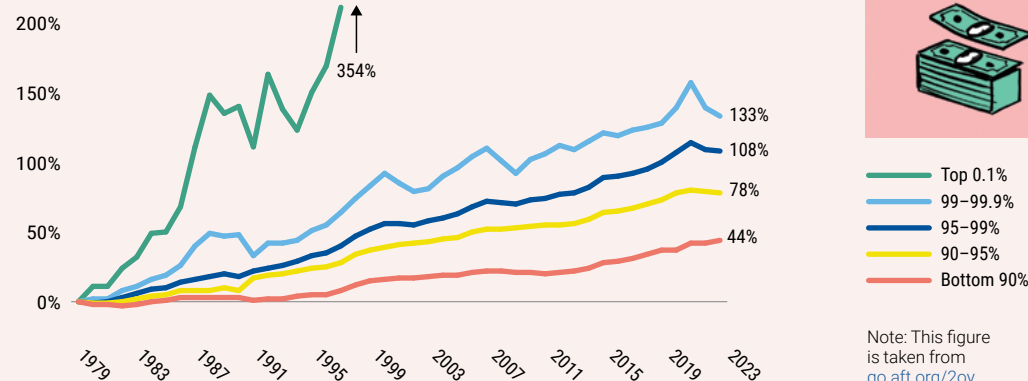
If typical workers' pay had risen in line with productivity growth since 1979, their hourly pay would be 43 percent higher today.

Many of the same people who have been privileged enough to insulate themselves from wage suppression are also privileged enough to have excellent accountants who can make their incomes appear in whatever form results in the lowest taxes.⁷ For example, CEOs are overwhelmingly paid with "performance-based" measures, which means measures tied to the value of their companies' stock prices.

FIGURE E

Growing Inequality *Within* Wage Incomes Accounts for Most of Inequality's Rise

Growth in Average Annual Earnings Since 1979 by Percentile Groups, 1979–2023



Twenty years ago, the large majority of this stock-based pay for CEOs came in the form of stock options, which are contracts that give the CEO the right (but not the obligation) to buy shares of stock at a set price. If the market price went above this set price, CEOs could exercise these options and pocket the difference as pay. The gains from exercised stock options are recognized by the IRS as labor income, taxed accordingly, and classified in data as labor income. But over the past two decades, there has been a pronounced shift in the stock-based pay of CEOs away from stock options and toward the outright granting of stock. In this case, CEOs are not given a right to buy shares at a preferential price; they are simply given shares.⁸ What's important for the split between capital and labor incomes is that these non-option forms of stock-based compensation are far less likely to be captured in measures of wage incomes. So this tax evasion strategy artificially depresses estimates of labor income in the economy.

The Shift from Labor to Capital Incomes

While most of the pay-productivity gap stemmed from the rising inequality within

labor earnings discussed above, a nontrivial portion of this gap stemmed from a shift in overall income from labor to capital. This goes far beyond the tax avoidance trick described above for CEO compensation—including paying regular working people less so that shareholders get more. If, for example, a corporation were able to suppress its workers' pay while raising customers' prices and/or cutting what it paid suppliers (which generally means those suppliers paying their workers less), it would earn higher profits. By successfully suppressing wages to boost profits, American corporations have made their stock more valuable. Imagine an investor buys \$100 in company stock with the expectation of an annual return of \$5. If the company undertakes a successful campaign of wage suppression that boosts annual returns to \$10, many other investors will buy company stock—bidding up share prices.

So even though this labor-to-capital shift in overall income is the smaller player in generating overall income inequality, it still had profound effects on American economic life. Estimates indicate that anywhere from 40 percent to nearly 100 percent of the entire nominal gains in the US stock market since 1989 can be attributed to this shift of income from workers to capital owners.⁹

The rise in US stock prices in recent decades is a key driver of another kind of economic inequality: inequality of wealth.* One of the primary sources of wealth, the ownership of corporate equities (e.g., shares of stocks), is incredibly concentrated; the top 10 percent of households own about 85 percent of all corporate equities, and the top 1 percent own nearly 40 percent.¹⁰

The concentration of corporate equities combined with the role of wage suppression in making these equities far more valuable leads to a clear implication: The wage suppression of recent decades is not just by far the biggest driver of the rise in *income* inequality; it is also

*Wealth is the value of a person's assets (e.g., the equity in their home, stocks and bonds in their retirement accounts, or their baseball card collections) minus the value of their debts.

by far the biggest driver of the rise in *wealth* inequality. Most of the rise in wealth inequality in recent decades has been the outcome of an intentional transfer away from workers to the top.

Labor Markets Are Not Fair

This rise in inequality in recent decades has attracted much attention from researchers—along with everybody else struggling to pay for groceries and keep the lights on. For a long time, economists' role in the debate over inequality was to look for reasons why well-functioning, competitive markets could generate lots of inequality. This often led to explanations that essentially blamed workers for the outcomes. The argument was that the fair and competitive labor market had spoken and that these workers were falling behind because their skills and efforts had been found wanting. The precise failure identified was often workers' alleged inability to adapt to the quickening pace of technological change in the economy.

But the evidence supporting this view of inequality driven by apolitical forces working through fair and competitive markets was incredibly thin.¹¹ That led many researchers to examine whether labor markets are by their very nature tilted against workers, making it very difficult to secure regular raises that match overall economic growth.

There is ample evidence for this view—that excess employer-side power makes labor markets generally unfair and inefficient, and that truly fair, competitive labor markets are the exception, not the rule. For example, many employers, and particularly those of low- and moderate-wage workers, rarely if ever negotiate pay; instead, they post take-it-or-leave-it wage offers.¹² And when a given employer lets its wages lag behind those of potential competitors, workers' exit from the lower-wage firm is far less common than would be predicted under truly competitive labor markets (where employers robustly compete for workers).¹³

This employer-side power is rooted in many obvious factors in real-world labor markets that make it hard for workers to effectively

search for better jobs and, therefore, force employers to compete over them. These include things like lack of information about wages and benefits offered by other employers, transportation restrictions that require workers to look for jobs only in places near their homes or public transit nodes, and childcare considerations that require a job's location be compatible with picking up kids at a regular time, along with many other factors.

Wage suppression is not just the biggest driver of the rise in *income* inequality; it is also the biggest driver of the rise in *wealth* inequality.

Another barrier to competition is the obvious fact that in the short run, most employers need the income a new worker would generate for their business far less than most workers need the income from a job. In a jobsite of 100 workers, having a month go by understaffed by a single worker reduces business income by roughly 1 percent. In a household with a single worker, having a month go by without a job reduces income by essentially 100 percent.

Employers exploit these barriers to employees finding better options by “marking down” wages below what would be necessary for employers to attract and retain workers in competitive labor markets. These markdowns can be large enough to push workers' pay well below the value they produce for the employer (i.e., below the “market clearing” wage). This makes them not just unfair, but inefficient—a drag on economic growth.



Key Policy Choices That Led to Rising Inequality

Having realized the role of employers' power in determining labor market outcomes, the importance of specific policies is magnified. For example, before the 1990s, many economists were extremely skeptical that minimum wages could do much good in raising wages without steep downsides like job loss. Why? Because they erroneously used models of *competitive* labor markets.

But more accurate models that include employers' power reveal significant room to raise minimum wages without generating job losses. The evidence over the past 30 years has been highly persuasive that minimum wages could be much higher than they were in the 1980s and 1990s without causing job losses and that the benefits for low-wage workers would be large.¹⁴

The period of rising inequality since 1979 was one of profound institutional change in labor markets. The federal minimum wage, for example, lost 35 percent of its value between 1979 and 2025 as legislative inaction (i.e., not raising it) allowed it to be battered into irrelevance by inflation.¹⁵ This was also a period that saw a pronounced acceleration in the decline of unionization rates of American workers.¹⁶ It was a time when high levels of unemployment were tolerated by policymakers for extended periods in the name of fighting inflation.¹⁷ And it was a time when increasing integration between the rich United States and a poorer global economy was done on terms that were written by and for corporate interests.*

Several years ago, researchers at our organization, the Economic Policy Institute, reviewed the research on how much specific policy choices likely contributed to growing inequality. Adding together the impacts of the changes like those listed above could easily explain the lion's share of the rise in inequality since 1979.¹⁸

For example, one key policy change was the practical abandonment of the Federal

Reserve's full employment mandate. By law, the Fed is supposed to pursue both stable inflation and full employment (which means trying to keep unemployment as low as is consistent with stable inflation). But between 1979 and 2007 (right before the Great Recession), the Fed largely acted as if it did have a mandate to pursue stable inflation but did not have one to pursue full employment.

Declining unionization likely explains a quarter of the pay-productivity gap since 1979.

After the Great Recession, the Fed admirably reversed course and tried to push the economy back to full employment, but its tools proved too weak given the magnitude of the shock. In such situations, fiscal policy—taxes and spending—should be used aggressively to restore full employment. But in the 2010s, political gridlock and excess caution kept policymakers from doing this, and much of that decade was plagued by excess unemployment.

Excess unemployment does not just leave willing workers locked out of jobs. It also saps the ability of still-employed workers to demand raises. For nonunion workers, their chief leverage for getting wage increases is threatening to quit. This threat is only credible when unemployment is low. Consequently, the too-high unemployment rates for most of the period from 1979 to 2019 were a drag on wage growth. In our estimates, too-high unemployment may well have explained nearly a third of the entire pay-productivity gap over that period¹⁹—not to mention the devastation it wrought for millions of families.

Another key policy change was the failure to keep the playing field level between workers looking to organize and join unions and the employers who wanted to stop them.

The National Labor Relations Board is supposed to safeguard this right, but its tools have proved too weak in the face of fierce employer opposition to unions, and policy changes to strengthen these tools have consistently been blocked. The results of throttling the growth of new unions have been profound; our estimates are that declining unionization likely explains a quarter of the pay-productivity gap since 1979.²⁰ Crucially, the decline in unionization did not just hurt workers who otherwise would have been unionized. By far the biggest of the wage-suppressing effects of deunionization has been on the broad pool of nonunion workers. As unions lose strength, they stop being able to set industry-wide pay standards that even nonunion employers feel like they have to meet to avoid hemorrhaging employees.

The wage-depressing effect of trade flows from poorer nations—flows encouraged by the corporate-led trade agreements the United States has signed in recent decades—can likely explain another 10 to 15 percent of the pay-productivity divergence since 1979.²¹

The Wrong Incentives

Tolerating excess unemployment, throttling workers' ability to join unions, failing to update the minimum wage as costs rise, and signing corporate-friendly trade agreements were some of the many instruments of wage suppression undertaken and abetted by

policymakers in recent decades. At the same time, choices legislators made on tax policy boosted the incentive for capital owners and corporate managers to aggressively use these instruments to increase their wealth.

When ultra-high incomes and corporate profits are taxed at high (i.e., appropriate) rates, the incentives for powerful individuals to rig the rules of markets to suppress regular workers' wages are much smaller. Key research shows that this incentive effect is real and powerful. For example, across countries, the larger the tax cuts on the rich enacted in recent decades, the greater the increase in *pre-tax* inequality.²² And, the lower the top tax rates for individuals, the higher the levels of *pre-tax* CEO pay.²³ High taxes reduce the benefits of rule-rigging, so cutting taxes increases rule-rigging. This means that raising taxes on the richest households and corporations results in new revenue *and* more equal *pre-tax* incomes. But from the mid-1970s, tax rates for high-income households and corporations have been cut steadily and deeply in the United States, reducing both tax revenues and wages for working people.

Income Inequality, Not High Prices, Is Behind the Affordability Crisis

We opened this article with a claim that affordability is the outcome of a race between income



*For details, see "A Trade Policy That Puts Working Families First" on page 28.

and prices. Our long walk through the economics and history of recent American inequality highlights that intentional policy choices have deprived typical households of income they could have otherwise claimed. Without this inequality, a middle-income household today would have tens of thousands of dollars more per year—and this would obviously make affording a decent life much easier.

But some might wonder if we have still given prices short shrift in how much they contribute to affordability challenges. We don't think so, for a number of reasons. We sketch three of them here.

First, all of the income, wage, and productivity statistics we have included in this article have been *real* (i.e., they have been adjusted for the impact of inflation). And it is unambiguously true that real (inflation-adjusted) incomes are the proper way to measure living standards and economic possibilities for households.

Getting distracted by price growth while missing what's happening with income will lead to wrong conclusions about economic performance over even relatively recent periods of time. Figure F compares two periods, both starting one year before a deep recession struck and then running five years: 2007–2012 and 2019–2024. In the first period, inflation averaged 1.8 percent, while in the second it ran more than twice as fast at 4.2 percent. Yet real (inflation-adjusted) wage growth for low- and middle-wage workers was far faster in the second period. For the lowest-wage workers, real wages fell by 2.1 percent in the first period but rose by 15.3 percent in the second. For workers in the middle of the wage scale, real wages fell by 1.5 percent in the first period but rose by 5.8 percent in the second.

Over very short periods of time (one to two years), it is true that a rapid spike in prices tends to drive down real incomes and wages. But over any longer period (even as short as three to five years), assessing how the economy is doing for typical families rarely bears much relationship to price growth.

Second, even when researchers adjust for inflation differently at different parts of the

wage and income distribution, the impact is modest. Such measures account for things like lower-income families spending a higher share of their income on rent and groceries and a lower share on vacations. But there are surprisingly small differences in overall price growth faced by families at different income levels. For example, from 2019 to 2025, when the price of housing and groceries was on peoples' minds for good reasons, the inflation rate faced by the bottom 40 percent of households was just 0.2 percent higher than for the top 20 percent of households.²⁴ In short, the growth in prices faced by different groups varies far less than the growth of their incomes and wages.

Third, a key insight in assessing affordability debates is that one person's cost is another person's income. If the cost of a pound of coffee doubles from \$10 to \$20, this constitutes \$10 of additional income that somebody is getting. Perhaps the coffee grower or the shipper or the grocery store shareholders or the CEO or the

cashiers or some other link in the supply chain is getting an extra \$10 (or several of them are getting some slice of it). This means that rapidly rising prices cannot result in less income overall, so they are highly unlikely to actually make an entire economy poorer. Instead, the groups that face only the price increase lose out while groups receiving the extra income win.

This fact that every price is an amalgamation of various income streams also means policymakers can more usefully target wage and income policies rather than price policies. Again, my bill at the grocery store pays for the wages of cashiers, the pay of the company CEO, the dividends to shareholders, the payments to suppliers, and more. Even if we're unhappy about this grocery bill, we likely don't want all of those price components to get squeezed. We probably want the wages of cashiers to rise while hoping to rein in CEO pay and shareholder dividends. Policies that only look to restrain prices—price controls, for example—make no such distinction, so we don't know who in the grocery supply chain will bear their burden (though we can guess it's more likely to be the cashiers than the CEO). But if we raise minimum wages, change labor law to allow more widespread unionization, and raise taxes on the ultra-rich and on corporate profits, we have a very good idea of which incomes will be boosted and which will get squeezed.

Creating a Fairer Economy

It is deeply depressing that intentional policy acts led to the enormous rise in inequality that is making life so much harder for so many people. If tens of millions of American households had tens of thousands of extra dollars in their bank accounts each year while billionaires had significantly less money, the country would be a much better and happier place.

What brings us hope is the knowledge that because the rise in inequality was not the inevitable outcome of a modern economy, it can be halted and reversed. Today's workers have the skills and abilities needed to support much higher incomes with no loss in efficiency or employment—if we change policy to give

Because the rise in inequality was not the inevitable outcome of a modern economy, it can be halted and reversed.

them these higher wages. This is excellent news. Of course, many of today's elected leaders—and their donors—have little interest in reducing inequality, so the road ahead is long. But the foundational ingredients for a fairer and more efficient economy are clear:

- Keep unemployment rates low for long periods of time and fight recessions fiercely when they inevitably occur.
- Restore the right to organize new unions and bargain collectively.
- Raise minimum wages, including the federal minimum wage.
- Enact rules for the global economy that support healthy wage growth, not just healthy corporate profits.
- Crush the incentive to rig the rules of the economy by raising taxes significantly on ultra-rich households and corporations.

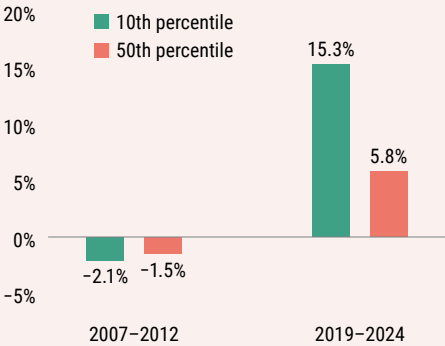
The details on how we create a fairer economy are more complex—and they do matter! But understanding that the affordability crisis facing American families is overwhelmingly an inequality crisis is a necessary and useful place to start.

For the endnotes, see aft.org/hc/fall2026/shierholz_bivens.



FIGURE F
In Recent Years, Low- and Middle-Wage Workers Saw Affordability Improve Even as Inflation Rose

Average Annual Growth in Real Wages for the 10th and 50th Percentiles, First Four Years of Economic Recovery



Note: This figure is taken from go.aft.org/k8q (Figure B in that report).

A Trade Policy That Puts Working Families First



By Lori Wallach

When it comes to trade, President Donald Trump is correct that decades of US policy have caused severe damage to many Americans and their communities. A core “America First” pledge by Trump was to end offshoring and bring factories and jobs “roaring” back,¹ creating family-supporting jobs for the 62 percent of US adults over 25 without four-year college degrees.² If that happened, it would boost local tax revenues to support schools and hospitals, and it would bolster our nation’s resilience and safety after COVID-19 supply-chain meltdowns revealed we can no longer make or reliably get essential goods.

But Trump’s chaotic tariff* policy is not delivering more industrial jobs or revitalizing domestic manufacturing. Since his return to the White House, more than 80,000 American

manufacturing jobs have been lost, and our manufacturing trade deficit has deepened by \$63 billion.³

The Trump administration may be unable to deliver, but the promises candidate Trump made are achievable. We can have a trade policy that:

- prioritizes the interests of workers, consumers, small businesses, and farmers;
- enhances national well-being, resilience, and security;
- increases capacity for American workers to be paid good wages;
- results in more quality goods and services produced in the United States;
- protects the environment and public health;
- balances trade, greatly reducing the trade deficit; and
- diversifies the nations from which we import.

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*For an introduction to tariffs, see go.aft.org/x41.

To accomplish all this, strategic, targeted tariffs are an important industrial policy for the US government. But as with any tool, proper use is essential. Trump’s off-and-on, go-it-alone deployment of tariffs—often aimed at the wrong targets and without accompanying domestic investment policies—has been akin to using a hammer to change a light bulb.

Today, far too many people face dead-end, low-wage job opportunities, no chance of owning a home, unaffordable and sometimes unavailable healthcare, and worse prospects for their kids. What happened to the American dream that has drawn people from around the world to our shores? There was nothing inevitable about the economic regime that delivered these outcomes. It was established by a specific set of expansive trade and economic rules implemented globally by international agreements, including the 1994 North American Free Trade Agreement (NAFTA) and the 1995 establishment of the World Trade Organization (WTO). As this article explains, different rules will deliver different results.

Corporate-Led Hyperglobalization

In the late 1980s, hundreds of official US trade advisors,⁴ mainly representing commercial interests, leveraged their access to trade-pact negotiations (from which the public, press, and even most of Congress were excluded) to shape binding global economic policies to their benefit. With the US government playing an outsize role in the negotiations, the NAFTA-WTO model was designed *by and for* the world’s financial-service titans and like-minded powers, including Big Pharma, manufacturers seeking to offshore production to lower-wage countries, large retailers, and agribusiness giants. It was pushed as a win for all Americans⁵ by US Republican⁶ and Democratic⁷ presidents alike amid the 1990s neoliberal mania.

While these pacts were branded as “free trade,” they were a radical departure from past trade agreements. Instead of being limited to traditional trade terms, such as tariff cuts and quota expansions, these pacts also

imposed one-size-fits-all rules covering *non-trade* matters.⁸ Every signatory country was required to make their *domestic laws* conform to expansive nontrade rules. And unlike labor or environmental treaties, these international rules were enforceable, with noncompliant countries facing trade sanctions unless and until they altered their domestic policies.

Strategic, targeted tariffs are an important industrial policy for the US government. But proper use is essential.

These rules are, predictably, anti-environment and anti-working families. They include bans on countries establishing new exclusively public services, requiring certain corporate structures (such as nonprofit status), or enacting certain types of licensing and other standards in specified service sectors. The United States was among the few countries that agreed to have any education services governed by these rules, allowing some aspects of adult and vocational education to be subject to the rules of the WTO’s General Agreement on Trade in Services. This agreement’s overarching purpose is to open all services (including education and healthcare) to private, international corporations and to make the provision of services across borders by private firms as easy as trade in goods. Under it, some educational programs could have standard practices like accreditation requirements declared “trade barriers” and dismantled.⁹ Fortunately, plans in the late 2000s to expand this to secondary and college-level education¹⁰ were defeated by a campaign led by unions and public colleges and universities.¹¹

NAFTA-WTO rules also forbid many forms of financial regulation, preventing bans on

risky financial products. Ceilings—but no floors—are set for domestic environmental, health, and safety standards. And, in a clever anti-antitrust move, the rules ban service-sector regulation¹² based on the size of an entity or how many different services any one entity may offer.¹³ (Pacts like these are still being developed. Recent ones include “digital trade” rules that undercut governments’ abilities to enforce policies on Big Tech competition, AI oversight, child online safety and data privacy, and security.¹⁴)

Trump’s second-term trade policy has demonstrated almost every possible misuse of tariffs.



Signatory nations also are obliged to enact and enforce pro-monopoly policies domestically. This includes extensive intellectual property protections, such as lengthy patent monopolies that raise medicine prices.¹⁵ As

well, countries are forbidden to enact many of the most effective measures to avoid financial crises and speculative bubbles, such as regulating flows of capital across borders.¹⁶

When consumer advocate Ralph Nader dubbed these deals “a slow-motion coup d’état” by corporations against governance and accountability,¹⁷ he was attacked as a Luddite and protectionist.¹⁸ The campaign criticizing him was funded by powerful commercial interests pushing their agenda through the

backdoor of “trade” agreements to achieve what they could not achieve in Congress.¹⁹ President Bill Clinton described globalization as a natural unstoppable force.²⁰

That’s far from the truth. In fact, the WTO and NAFTA were just one version of global commercial rules that were shaped to benefit certain interests—and they could be reshaped. Consider that free trade agreements, like NAFTA, included new investor protections that subsidized offshoring. To make it safer and less costly for corporations to offshore production to low-wage countries, the pacts require governments to guarantee investors a minimum standard of treatment and refrain from regulations that conflict with investors’ “reasonable” expectations. Called investor-state dispute settlement (ISDS), this system elevates individual corporations to equal standing with nations by empowering corporations to skirt domestic courts and sue governments before a panel of three *corporate* lawyers. The foreign corporation need only convince the lawyers that a law, environmental regulation, or court decision violates the special investor rights. The lawyers’ decisions are not subject to appeal, and they can award the corporations unlimited sums to be paid by a country’s taxpayers—including for the loss of expected future profits. Meanwhile, governments cannot sue corporations for bad conduct. More than \$100 billion is known to have been paid to corporations and investors by governments in ISDS attacks on zoning laws, bans on toxic substances, minimum wage standards, racial justice measures, mining rules, water and forestry regulations, and more, but settlements in most cases remain confidential.²¹

WTO rules have also been strongly enforced.²² Tribunals of trade experts could order governments whose laws were determined not to meet WTO dictates to eliminate or alter such policies or face indefinite trade sanctions. For example, as a result of WTO enforcement actions, the United States has rolled back Clean Air Act anti-asthma rules on gasoline contaminants, Endangered Species Act rules on sea turtles, the ban on tuna caught with nets

that drown dolphins, and the mandatory country-of-origin labels on meat.²³ Today, the WTO’s powerful enforcement mechanism, which has ruled that numerous countries’ environmental, health, and other public-interest policies were illegal trade barriers, has been sidelined after the first Trump administration vetoed the appointment of new tribunalists. But influential commercial interests in powerful countries have been able to enforce many of the old rules through other means, including, increasingly, the second Trump administration’s tariffs and resulting bilateral agreements that double down on terms that favor corporations.

Damaging Results at Home

After three decades, this global “trade” architecture has concentrated industrial production and many services that can be offshored (including engineering, accounting, computer programming, radiology, and back-office operations) in too few places. The rules promote “efficiency” in the form of low prices wrought from low wages and labor abuses, currency manipulation, and mass corporate subsidies. Under these rules, countries with higher standards and wages, and those seeking to raise them, are effectively penalized.

The result is US economic damage, which many Americans have been and are painfully experiencing, along with threats to national security, resilience, and democracy. That multiple US presidents pushed this global commerce regime makes these outcomes especially ugly.

The data are familiar and grim: A large, chronic US global trade deficit has fueled deindustrialization, with more than 70,000 American factories closing since 1995.²⁴ Since NAFTA and the WTO, millions of manufacturing jobs have been destroyed²⁵ nationwide by waves of offshoring and surges of imports—often of US brand-name goods that are no longer made here. Congress’s approval in 2000 of China’s admission to the WTO intensified the damage.²⁶ The growing US trade deficit and increasing job offshoring to low-wage countries have driven expanding income inequal-

ity.²⁷ And these policies were pursued despite the fact that economic theory predicts these terrible outcomes.

When towns’ industrial jobs were killed, local restaurants, retailers, and other businesses lost their customers and failed. The tax base that once supported local schools, hospitals, public infrastructure, and other services and related jobs shriveled. “Factory Towns”²⁸ nationwide were crushed along with the families who had built lives around them.*

US policymakers chose to ignore all of this for years. The fallout has been deep and lasting. Today, 59 percent of Americans—about the same as the percentage of the workforce without college degrees—say they cannot cover an unexpected \$1,000 expense.²⁹ Working-class Americans have an average lifespan that is eight years shorter than those with college degrees.³⁰ A recent demographic study of areas hardest hit by manufacturing job losses to Mexico following NAFTA shows “lost years” that (after controlling for other factors) the authors concluded were NAFTA-related early deaths.³¹

Trade policy is not the only cause of these negative trends. But as a policy set by our government, it is a factor that can be shaped.

The rage accompanying this decline has translated directly into politics, with implications for American democracy. Research has documented intense political polarization on a precinct-by-precinct basis where the most severe trade-related damage occurred.³² Similarly, the opinion research conducted through the “Factory Town” project of medium-sized cities nationwide showed why driving through once-thriving manufacturing communities in New York, California, and Texas, one will meet the same decay, despair, and rage that are shifting the politics of Wisconsin, Pennsylvania, Ohio, and Michigan.³³ These cities once provided economic security for American workers without college degrees, but as factories left, whole communities withered.

*Another serious consequence of our chronic trade deficit has been hyperfinancialization of the US economy. This has been a boon for Wall Street but a disaster to most Americans.

Then the COVID-19 crisis happened, and millions of Americans who previously had felt immune to the downsides of corporate-led hyperglobalization were awakened to the threats of our current trade regime. In the most powerful country in the world, we realized in 2020 that we no longer produced the essential goods that keep our families safe, nor were there diverse import sources on which we could rely.³⁴ This unifying shock made evident what US military planners have long warned: We have become dangerously over-reliant on importing key goods from too few countries.



America has even become a net food importer, with agricultural trade deficits in four of the last six years.³⁵ We export raw commodities of soy, corn, and wheat and have become increasingly reliant on imports for the food that we eat, including up to 90 percent of seafood,³⁶ about 60 percent of fruit, and more than a third of vegetables.³⁷ The rigged trade rules mean that for soy, the United States is both the world's second largest exporter (51.2 million metric tons)³⁸ and a major importer.³⁹ Consider the climate disaster of ships brimming with soybeans spewing carbon as they pass each other on the seas. Who benefits from this madness? A small number of multinational commodity firms profiting by paying farmers in the United States, Brazil, and elsewhere less while controlling sales to the United States, China, Japan, and other countries to maximize margins.

Despite the many constraints on countries' domestic policies imposed by the WTO, NAFTA, and similar agreements, they included no discipline against trade-distorting tools

that lead to chronic imbalances, including currency manipulation, wage and consumption suppression, and some forms of subsidy that fuel overproduction. For example, countries can lower their currency values to boost exports. Imported goods priced in undervalued currencies now often enjoy enormous advantage in the US market relative to even the most efficient domestic producers. As well, during the 1970s, newly formed transnational corporations pushed key countries to "liberalize" their investment regimes. That meant US brand-name corporations could more easily move production to low-wage countries.

Over time, the US trade deficit with the world deepened, as offshoring expanded into the most sophisticated manufacturing sectors. Consider solar. Solar energy was a US innovation. In the 1990s, we produced one-third of all solar equipment worldwide.⁴⁰ But by 2015, after decades of predatory trade practices by China and other countries (combining currency devaluation, large industrial subsidies, and other practices), the United States produced almost no solar equipment.⁴¹ Today, 80 percent of solar equipment production occurs in China.⁴²

That example—repeated in the case of computers, microchips, and many other innovations—gives a glimpse into why the United States had an almost \$1 trillion trade deficit by 2022.⁴³ It also points to another problem: As US job offshoring to China and India has moved up the wage scale, to highly skilled manufacturing jobs and even to professional jobs, US workers now lose more from reduced wages than they gain from cheaper imported goods, as the father of modern trade economics, Nobel laureate Paul Samuelson, showed in a 2004 paper.⁴⁴

In short, our longstanding trade regime has become a bad deal for most Americans.⁴⁵

Damaging Results Abroad

Perversely, the countries that have done the best under this corporate-friendly system are those, like China, that have found ways to evade its rules.⁴⁶ Countries in Latin America

and Africa that adhered most closely to the entire neoliberal policy package saw their growth rates slow and income inequality increase.⁴⁷ Many also became net food importers and subject to serial food-price crises, as WTO rules forbid certain forms of support for small farmers but allow export subsidies.⁴⁸ Some countries in Asia, including China, bent WTO rules to spend heavily on subsidies. They developed industrial sectors that paid low wages—but relative to the grinding rural poverty that millions of Chinese people were enduring, they provided real gains. But well after China and other Asian nations grew into world-class manufacturers, their governments' subsidies continued to expand and currency manipulations continued. These nations also grew significant chronic trade surpluses with the world.

Today, global trade has become so imbalanced and production so concentrated that fewer than 20 nations, mainly in Asia and Europe, have large chronic global trade surpluses (unrelated to exports of oil or other natural resources). China's is the largest at \$1.2 trillion.⁴⁹ A recent International Monetary Fund report called on China to reduce its subsidies, warning that its overproduction was distorting trade worldwide.⁵⁰ But some other nations' average current account surpluses relative to their GDPs in the past decade are also sizeable: 7 percent for Germany, 3.5 percent for Japan, 4.2 percent for Korea, and 25 percent for Taiwan (according to calculations made by Rethink Trade staff). As many of the chronic trade-surplus nations flood the world with huge volumes of goods of all types, more countries have joined the United States in having chronic global trade deficits.

The tragedy of this story is that trade imbalances hurt regular people in both surplus and deficit nations. Many people are aware of the damage caused by chronic trade deficits. But people in nations with chronic trade surpluses, such as China, often face suppressed wages, meager social safety nets, undervalued currencies, and other troubles. This tradeoff might be acceptable for developing coun-

tries seeking to kickstart domestic industries. However, when large, industrialized nations keep depending on foreign markets to absorb production surpluses, imbalances begin to build up and generate destabilizing effects. Now, large middle-income nations like Brazil, India, and Turkey are facing deindustrialization pressures and, as a result, have enacted tariffs against Chinese imports.⁵¹

As if all this weren't bad enough, millions died needlessly during the COVID-19 pandemic because of the WTO's overreaching, corporate-rigged "trade" rules. European countries with major pharmaceutical industries blocked a proposed waiver to WTO patent monopoly guarantees that was needed to produce generic versions of the best vaccines and treatments.⁵² It was an extreme display of "trade" rules enforcing the profits-over-people mentality that corporate leaders routinely champion.

Why Trump's Approach Is Failing

While Trump seized politically on the fallout of this long-simmering trade disaster, his diagnosis of why our trade policies cause so much damage is wrong. Trump says other countries tricked "stupid" US trade negotiators into "bad" deals.⁵³ In fact, Republican and Democratic US presidents alike promoted NAFTA and WTO terms that favored large commercial players. And now Trump is using trade tools—mainly tariffs—to benefit his own political and personal allies⁵⁴ while also committing tariff malpractice that benefits no one. Indeed, Trump's second-term trade policy has demonstrated almost every possible misuse of tariffs.

Tariffs have been a common tool to penalize bad trade conduct for decades. Tariffs balance against subsidies and dumping (selling goods for less than what it cost to produce them) that would otherwise wipe out domestic producers. Tariffs are also an important policy tool to create preferences for certain production practices.

For example, if you are concerned about climate change and favor the Carbon Border Adjustment Mechanism that Europe has

enacted to reward lower-carbon production, you are for tariffs. If you think it is unfair for US shrimpers, mainly small businesses with one or a few trawlers, to get wiped out by imported shrimp from India, Vietnam, and other countries (produced with subsidies and processed under horrific labor conditions after being grown in unsanitary pools where fecal contamination is countered by antibiotic soup⁵⁵), then you support the countervailing tariffs now in place against those imports. If you do not want solar panels made by forced labor and believe the United States should also produce this technology that we created, you support tariffs against China's use of massive subsidies and dumping of such goods (and against Chinese panels being sent through other countries).

But Trump's chaotic tariff policy has minimized tariffs' trade-balancing and reindustrialization prospects while doubling down on trade agreements designed to benefit powerful US commercial interests. His tariff overreach helped spur a 6-3 Supreme Court ruling in early 2026 stating that Trump did not have authority *under a specific statute*, the International Emergency Economic Powers Act,⁵⁶ which he had used to impose the broadest tariffs covering the most countries. Trump quickly reinstated tariffs using other tariff authorities Congress has provided to presidents for decades.

Legalities aside, the first and most fundamental problem is that Trump keeps violating the number one rule of effective tariff use: Tariffs only work when they are predictable and sustained. No company will shift input or retail sourcing, much less invest in new or expanded US domestic production capacity, unless it believes the demand for domestic goods generated by protection will last long enough to earn a return. Trump's tariff roller coaster—which has included more than 50 major changes in tariff rates, target countries, and excluded goods in one year⁵⁷—sends the opposite message.

Second, Trump has mistargeted tariffs by using them to benefit himself, his political donors, and politicians he favors in other

countries instead of the American people. In his zeal to gild what he calls his “very good relationship” with Chinese leader Xi Jinping,⁵⁸ Trump cut tariffs on China,⁵⁹ a major source of our trade problems. But he imposed 50 percent tariffs on Brazil, a country with which we have a trade surplus, in a fit of anger about Brazil's former right-wing president, Jair Bolsonaro, being sentenced for an attempted coup.⁶⁰ After the government of Vietnam fast-tracked approval of a major golf resort complex the Trump company wanted to develop, Trump cut Vietnam's 46 percent tariff rate dramatically despite a very large and growing US trade deficit with Vietnam.⁶¹

Third, Trump is misusing the tariff tool. Tariffs are a defense against unfair imports that would otherwise meet domestic demand and deprive US producers of a fair market, thus chilling investment in new capacity or crushing domestic production. Instead, Trump eliminates tariffs on countries with large trade surpluses if they sign “Agreements on Reciprocal Trade” that require them to roll back environmental and consumer protections and regulations disliked by people or industries close to Trump (such as US Big Tech, Big Pharma, and Big Ag).⁶² To the extent these deals focus on trade at all, it is by eliminating other countries' tariffs and therefore boosting US exports. But it is simply impossible for the world's global trade deficit countries to export their way to balance. The problem is on the import side and with overproduction by a few nations. Trump is not using his leverage related to tariffs and access to the US market to demand changes to export-maximizing policies, including those that allow countries to evade somewhat higher tariffs by raising subsidies and altering currency values.

Fourth, Trump's disdain for international cooperation means unilateral US-imposed country-by-country tariffs cannot stop import workarounds that allow goods and value from China to enter the US market. While the higher tariffs on China applied in Trump's first term and increased under the Biden administration cut our bilateral trade deficit with China,

US trade deficits with Vietnam, Mexico, and many Southeast Asian nations grew significantly more.⁶³ That represented production from China entering the US market as parts assembled in those countries, as transshipment of actual Chinese goods, and as Chinese firms investing in other nations. In contrast, if tariffs were applied collaboratively by scores of countries against the countries using unfair trade policies, they could effectively counter such workarounds that otherwise defeat the goal of balancing trade.

Fifth, tariffs alone cannot build new production capacity, ensure Americans have reliable access to goods, or improve our security. That's why the Biden administration combined higher tariffs with tax, investment, procurement, and other industrial policy tools. As a result, by 2023 it fostered the greatest investment in construction of new US manufacturing plants in 30 years and achieved 150,000 more US manufacturing jobs than at any time in the first Trump administration.⁶⁴ Trump could have gained the political credit when the new plants started hiring, given that it takes years to get from industrial policy to investment to construction to hiring. Instead, he killed the Inflation Reduction Act electric vehicles and solar equipment reindustrialization program⁶⁵ that generated US consumer demand for these American-made goods. Worse, Trump terminated these Biden-era programs without any plan of his own. Not surprisingly, investment in factory construction declined by \$34 billion in 2025 relative to 2024.⁶⁶

Sixth, Trump has trashed important diplomatic relationships with tariff temper tantrums. For instance, he threatened European countries over his Greenland lust⁶⁷ and tariffed Canada over fentanyl it does not produce.⁶⁸ One result is that instead of cooperating with the United States to counter Chinese mercantilism and overproduction, potential partners are distancing themselves.

Finally, Trump has made so many nonstrategic and grifty exceptions that the tariffs' capacity to minimize unfair imports or create domestic demand has been undermined.⁶⁹ For example, stealthy tariff exemptions were given for cell-

phones, laptops, flatscreens, and more for Big Tech firms after Apple's then-CEO Tim Cook quietly worked Trump behind the scenes.⁷⁰ A year after “Liberation Day,” between legitimate exclusions to avoid double-tariffs and special one-off exemptions granted to countries and corporations that plied Trump with flattery and gifts (gold bars and a Rolex watch from Switzerland⁷¹), about 60 percent of US imports are exempt from tariffs.⁷²



Whether Americans get the trade policy we need will depend in part on whether we demand change.

This may surprise many Americans who have heard that the price increases they face are tariff-related. Tariffs can but do not necessarily raise retail prices.⁷³ US consumers only pay more if corporations that choose to import tariffed products or inputs also choose to pass on tariff costs to consumers in the form of higher prices.⁷⁴ In deciding if they will increase prices, corporations consider things like whether there are domestic goods or non-tariffed imports that could substitute for tariffed goods. According to analyses by Rethink Trade staff, roughly 30 percent of all US imports come from Mexico and Canada, much of which remain duty-free if they meet the terms of the US-Mexico-Canada Agreement (Trump's 2020 NAFTA replacement).⁷⁵

Another consideration is whether a good has a large markup. Fancy sneakers that con-

sumers pay \$150 for may enter the United States from Vietnam at a wholesale price below \$30.⁷⁶ Add even a 50 percent tariff, which is \$15, and the retailer can easily “eat” the cost while still making a substantial profit.

Some of what Americans have been told are tariff price spikes is actually price gouging on goods that are not subject to tariffs. Consider spiraling beef prices. Only 17 percent of beef consumed in the United States is imported,⁷⁷ so tariffs are largely irrelevant. Prices jumped because the four huge packing companies now controlling 85 percent of all US beef processing⁷⁸ have the power to charge consumers more (while also forcing ranchers to accept lower prices for their cattle).



Real Alternatives

While Trump’s trade agenda has not worked as promised, the health of the US economy and our democracy requires a more balanced trade system with more distributed production that delivers broad economic benefits. This would restore a sense of economic security for more people, uniting Americans across regions and political lines.

We must build on the broad industrial policy approach the Biden administration started. The 2020 national supply chain reports identified the main items we need to produce more of ourselves. For our resilience and health, we cannot remain 90 percent reliant on imports of essential medicines from a few countries.⁷⁹ For our stability and competitiveness, we must produce more of what we need for our basic infrastructure, from steel and microchips to cutting-edge batteries and communica-

tions gear to solar and wind equipment. For our security, we must produce aerospace equipment, ships, and rare-earth magnets. In each sector, we need a strategy that starts with education and training to develop our workforce.* We must enact tax policies that incentivize investors to create new production capacity and consumers to purchase US-made products. Key sectors will require direct government investments as well as repairing domestic procurement preferences so that our tax dollars are reinvested through purchasing US-made goods. But WTO- and NAFTA-style trade deals forbid many such policies.

Even the smartest domestic policies will fail if they must operate in the global context established under the old international trade rules. A post-Trump administration can shift direction by partnering with the many other nations suffering from chronic global trade deficits, and with countries that have balanced trade, to build international trade arrangements explicitly premised on reversing and then preventing chronic global trade imbalances. This would force more distributed production, allowing more nations to benefit from trade, and it would build resilience with multiple supply chains for key goods. It would also reduce the carbon footprint of long-distance shipping of many categories of goods that are currently only made in one or two distant countries. And, if trade under a pro-balance system were conditioned on participating countries enforcing anti-monopoly rules and international labor and environmental standards, it would help distribute production and create fairer markets while improving wages and our health.

Establishing a floor of decency, with labor and environmental standards and fair markets with anti-monopoly rules, would help ensure global trade helps support, not erode, the high-wage, healthy, green economies to which most nations aspire. Ending the proscriptive

*To read about the AFT’s partnership with Micron Technology to prepare students for jobs in its semiconductor fabrication facilities, see “Advancing Tech Dreams” in the Spring 2024 issue of *American Educator*: go.aft.org/nlu.

WTO-NAFTA one-size-fits-all international commercial rules would open policy space for diverse industrial and other domestic policies to achieve these ends.

For such a system to work, trade among countries that agreed to follow this very different set of rules would be at lower tariff rates, although with space for countries to set higher tariffs on goods in sectors where more domestic production is a goal. Countries outside the system would face considerably higher common external tariffs. This is a critical, but difficult, aspect: Without the external tariffs, trade from countries not meeting the rules would “leak” into the system and undercut the economies of those who meet the terms. Therefore, countries with chronic global surpluses would have to choose. Some might decide it was worth altering their policies to join balanced, high-standards trade arrangements. The common external tariffs also would force surplus countries to consume more of what they produce, which would be a win for their domestic consumers and help balance trade.

What Comes Next

The United States is currently facing a significant action-forcing trade-policy moment. The US-Mexico-Canada Agreement terms required that by July 1, 2026—six years after its start—the signatory countries had to determine whether they would extend the agreement as-is for another 16-year period, agree to revised terms, or try to renegotiate and extend it during a period of annual reviews until the pact ends on July 1, 2036. Elements of the high-standards balanced trade approach could easily be adopted by the United States, Mexico, and Canada in negotiations that will clearly extend into 2027.

Some Democrats in Congress are developing legislation to describe a true alternative to both WTO-NAFTA corporate-led neoliberalism and Trump’s unilateral corporate-led tariff coercion. The Fair Trade for Working Families Resolution (H. Res. 1286) was introduced in May 2026 by Rep. Rosa DeLauro (D-CT) and nearly 30 House Democrats. It outlines a new, worker-centered

vision for trade policy to shift away from agreements that prioritize corporate interests.⁸⁰

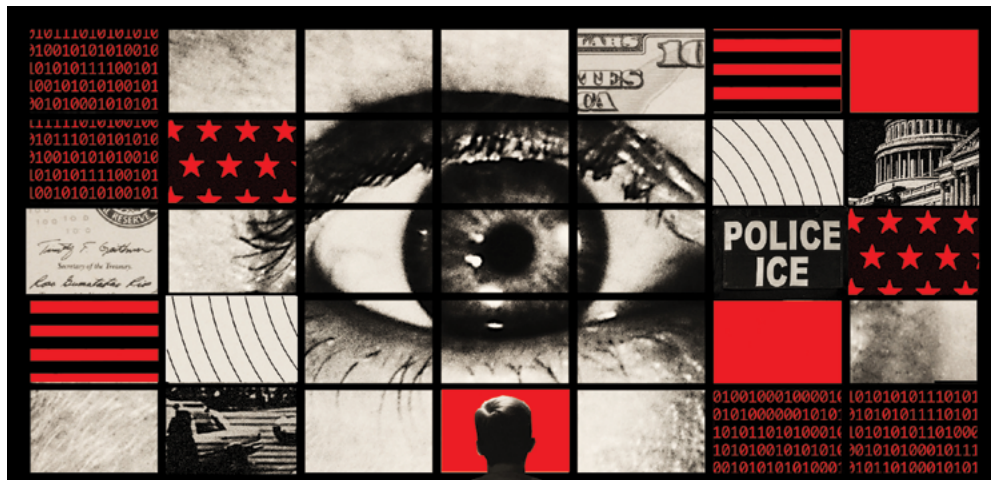
But whether Americans get the trade policy we need will depend in part on whether we demand such change. Millions of Americans calling, writing, and bird-dogging their members of Congress is why the United States did not join the 2015 Trans-Pacific Partnership deal, which was essentially NAFTA on steroids.⁸¹ And an international campaign of unions and activists stopped a mid-2000s effort to greatly expand WTO service-sector privatization and deregulation rules into primary education and other sectors.⁸² Likewise, a NAFTA expansion to 15 more nations, the Free Trade Area of the Americas, was derailed in the early 2000s by internationally linked, country-based campaigns of union, environmental, and other activists in numerous nations.⁸³ And the 1999 “Battle in Seattle,” in which 50,000 Americans took to the streets against the WTO, helped derail a major expansion of the organization’s power and scope.⁸⁴

Today, Trump’s trade agenda is hurting tens of millions of Americans whose livelihoods and communities desperately need the economic improvements he promised. And Trump’s tariff malpractice is being exploited by the powerful beneficiaries of corporate-led hyperglobalization—which include Trump himself—to drag us backward.

It’s time for the American people to see beyond political divides and realize that all working families need relief. We need trade policies that support workers, protect the environment, and revitalize the production of goods that are critical to our health, stability, and safety. Recent history shows that when we rise up, legislators listen. So over the next few months or years—however long it takes—make time to ensure your representatives hear from you regularly. Speak up for yourself and your community. Demand that, at long last, we adopt trade policies that put working families first. +

For the endnotes, see aft.org/hc/fall2026/wallach.

People Power and Advancing Rights, Justice, and Democracy in the AI Age



By Nicole A. Ozer

You may not know what “surveillance capitalism” is—but when you use most internet websites or smartphone applications, you are caught in its web. Information about who you are, where you go, and what you do is being collected and used to power astronomical wealth concentration by companies and rampant government surveillance. The power of artificial intelligence (AI) is poised to further

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supercharge this alliance between company profits and government interests, adding to the heavy costs that surveillance capitalism business models already impose on rights, safety, health, economic opportunity, and democracy in the modern digital age.

For more than two decades, we have increasingly relied on new technology to connect, communicate, work, and learn. Now that we live digital lives, we need to ensure that technology is working for us, not against us. We must build our collective power to fight for freedom, justice, and opportunity on the digital terrain.

Whether technology helps or hinders struggles for fairness, rights, and justice depends on why it is built, who has access to

it, and how it can be used. Ninety-six percent of US adults use the internet,¹ most children use school-issued computers and have access to school email addresses,² and 95 percent of teens have access to smartphones.³ By March of 2026, more than half of US teens had also used an AI chatbot for finding information and doing schoolwork.⁴ Most of us are aware of how ubiquitous technology has become, but many of us still don’t realize the true costs of many of these “free” services to our lives and livelihoods, or to the future of our country.

Technology is being used by the government to invade our privacy, undermine our right to free expression, sway elections, suppress democracy, and fuel immigrant deportation and discriminatory policing.⁵ The corporate sector is rife with surveillance business models and biased algorithms that prioritize profit over people’s health and safety. When challenged, Big Tech and government often align as a well-funded surveillance lobby to preserve the privacy-violating practices that make a handful of companies hundreds of billions of dollars per year. This concentration of wealth and power and the corresponding lobbying influence is growing as AI amplifies surveillance capitalism’s reach.

The path to our current digital reality began in the late 1970s when, at the dawn of the modern digital age, US policymakers largely failed to pass laws that matched the power of new technology.⁶ Our political leaders generally opted to rely on the efficacy of weak, procedural safeguards instead of creating robust rules of the road to protect people against government surveillance or limit how businesses could collect or use personal information. Some states, like California, have enacted stronger constitutional and statutory privacy protections.⁷ But federal laws restricting surveillance have remained woefully outdated, and consumer privacy laws have largely been locked for 50 years in a safeguards approach reliant on a notice-and-consent framework (including all those “I agree” buttons on the internet). As law professor Daniel Solove explains, the ability of this approach to protect people “is beyond broken; it is a complete fiction.”⁸

We live in the aftermath of the failure of our elected leaders to enact baseline laws that actually protect people and society. The result has been unbridled surveillance capitalism: the widespread collection and monetization of our personal information for profit.⁹ As this article explains, if we are going to be in a position to make technology work for us, we must better understand what surveillance capitalism is, how we got here, what is truly at stake, and how we can build the power to make sure lawmakers take the action necessary to advance rights, justice, and opportunity in the AI age.

Technology is being used by the government to invade our privacy and suppress democracy.

A Brief Introduction to Surveillance Capitalism

Every day, billions of us go online to search, shop, or connect with others; each click creates a trail of personal information in the form of search and chat histories, location information, photos, and more. These digital footprints track our movements, habits, interests, and associations. The surveillance business models of most of the major technology companies are based on collecting and using vast amounts of our personal information, often in complex ways. Many of these companies then use these detailed digital footprints—dossiers about who we are, where we go, what we do, and who we know—to target lucrative online advertising and tailor online apps.¹⁰ Some tech companies also sell our personal information to additional third-party companies, often referred to as data brokers, who then package

and further resell it.¹¹ Once companies collect our information, it can also often be accessed by the government for surveillance.¹² This vast information-sharing and -selling ecosystem has facilitated microtargeting that can be used to harm people, including financially vulnerable and marginalized groups.¹³



How did we get here? Why has the modern technology that was promised to pave paths to greater opportunity and justice often ended up leading to more closed doors?

In the late 1960s and early 1970s, there was a growing movement for robust, substantive privacy protections that would support civil rights and prevent emerging technology from exacerbating and perpetuating government abuses and economic inequality. Civil rights leaders like Dr. Martin Luther King Jr.; activists advocating for women's, Indigenous, LGBTQIA+, and farm workers' rights; and members of antiwar movements were targeted by new government surveillance technology, and many viscerally understood its power and the importance of a just vision of the future of technology.¹⁴ In his final public sermon before his assassination, King specifically highlighted the intersections of the "technological revolution with the impact of automation and cybernation" and the fight for human rights.¹⁵ Grassroots organizations like Computer People for Peace¹⁶ and larger organizations like the American Civil Liberties Union¹⁷ warned about threats of government surveillance and corporate information collection on personal lives, democracy, and society. By 1972, the Black Panther Party's Ten Point Program also included an explicit provision about "people's community control of modern technology."¹⁸

This support for stronger privacy rights saw an early great success with the passage, by state ballot measure, of the California constitutional right to privacy in 1972. At the core of the California constitutional right to privacy is an allocation of power to protect people against the combination of government, corporate, and technological power that could stack the deck against people's rights. With its passage, California's constitution became the first in the nation—either federal or state—to include an explicit right to privacy and protection against privacy intrusions that applied to both government *and* business actions.¹⁹

But further efforts were largely stymied by the mid-1970s, with passage of only some limited laws like the federal Privacy Act of 1974.²⁰ This law was inadequate when it was enacted more than 50 years ago, and its "soft spots"²¹ and loopholes have become particularly salient today, with digital coups by the so-called Department of Government Efficiency and other recent actions of the federal government.²²

What Went Wrong

Privacy law faced a fork in the road by the late 1970s. One path, championed by advocates for civil and workers' rights, would have created a robust constitutional and human rights-based vision of privacy that limited how personal information could be collected and used by the government and private companies. The second path, promoted by business interests, relied largely on self-regulation or weak procedural safeguards, such as notice-and-consent frameworks, that do not legally prohibit what or how personal information can be collected or used.

Then and continuing today, policymakers generally took the second path. The Electronic Communications Privacy Act, the federal privacy law that is supposed to limit government surveillance of electronic communications, has not been meaningfully updated since 1986,²³ when cellphones were the size of bricks and the World Wide Web did not even exist.²⁴ There was growing momen-

tum in the late 1990s to update privacy laws for the internet age. But then the events of September 11, 2001, scared policymakers into believing that the government needed more extensive surveillance capacities. Existing protections were undermined by the passage of the USA PATRIOT Act,²⁵ and political efforts to strengthen privacy laws for the modern digital age were derailed.²⁶

On the consumer side, this second path has given rise to the default "I agree" and "I consent" buttons that are now rampant on the internet. Many federal- and state-level privacy laws put the burden on individuals to try to protect their privacy in this largely ineffective way rather than ensuring that there are substantive limitations on how our personal information is collected.

As technology has developed exponentially, the laws to protect people have remained in the digital dark ages.

Amid this inadequate privacy-law landscape, there have been some advances at the state level. In addition to the passage of the California constitutional right to privacy, other important state laws—like the California Electronic Communications Privacy Act—have filled gaps by requiring a warrant for a government entity to search devices or demand that technology companies turn over electronic communications information, including emails, text messages, AI prompts, and location information.*

But the overall picture is that as technology has developed exponentially, the laws to pro-

*Full disclosure: I spearheaded the passage of this California law.

tect people have remained in the digital dark ages. Civil rights leaders of the 1960s and 1970s viscerally understood the need to take action to ensure that the power of new technology worked for freedom and justice. But we have not been able to mobilize the social movement power necessary in recent decades to properly update privacy law for the digital age. And in that absence, surveillance capitalism was born and allowed to flourish.

How Surveillance Capitalism Works

While the path to surveillance business models started in the 1970s, the current surveillance capitalism business model was not truly developed until the late 1990s. Leaders at dot-com companies like Google realized they could leverage advances in technology to extract, store, and process people's personal information on an unprecedented scale and monetize it for targeted advertising. To accomplish this, the technology industry developed a four-step process: (1) lure people with "free" products and services to grow the user base as quickly as possible; (2) collect information about people as they used those "free" services; (3) monetize that information by selling targeted advertisements; and (4) profit richly.²⁷

In the years that followed, many companies in Silicon Valley and beyond adopted and iterated this strategy.²⁸ They continually refined how much personal information their services could harvest, how to encourage people to visit their websites more often and stay longer, and how partnerships across platforms could share more information and support more profit.²⁹

As professor Shoshana Zuboff, the author of *The Age of Surveillance Capitalism*, explains, "Surveillance capitalism now reorders every domain of economic activity.... Every product called 'smart' and every service called 'personalized' is part of this regime."³⁰ Or, in the words of professor Zeynep Tufekci: "We're building this infrastructure of surveillance authoritarianism merely to get people to click on ads."³¹

The web of surveillance capitalism travels with you everywhere you go. Your smartphone

is a surveillance device in your pocket, purse, or backpack, taking copious notes on where you go and what you do. When you use applications, everything from health tracking apps³² to a flashlight app,³³ you are often paying a very high personal price because many apps make their money by selling personal information, like your location, to others in the mobile advertising ecosystem.³⁴ This can also include the multibillion-dollar data broker industry, which collects vast amounts of personal information by scouring available sources to create detailed dossiers on almost every American adult.³⁵ They have databases of people labeled with everything from “getting divorced” and “30-, 60-, 90-day mortgage lates” to “sexual orientation,” “erectile dysfunction,” “political affiliation,” “religion,” and far more.³⁶

If you find surveillance-powered ads ineffective, creepy, or invasive, you are not alone. Such *online behavioral advertisements*, which use our personal data to infer our interests, are unpopular; people consistently report that they do not like them.³⁷ Empirical studies have also found that online behavioral ads often push products that are more expensive and are from lower-quality vendors.³⁸ Sometimes the advertisements are predatory—like high-interest payday loans targeted to young people.³⁹ In other cases, they are discriminatory, as when advertisers push information based on age, sex, race, ethnicity, or income

level, resulting in certain groups receiving information about opportunities that others do not—such as potential jobs or housing opportunities.⁴⁰ The Federal Trade Commission recommended in 2022 that people opt out of targeted advertising to protect themselves.⁴¹ But the current pervasiveness of online tracking and the operational challenges, including “dark patterns” used by companies to make opt-out choices more difficult,⁴² make it functionally impossible for many people to opt out entirely.

There is growing concern with how the profit incentives of surveillance capitalism lead to downstream impacts on young people’s physical and mental health.⁴³ The growth of surveillance capitalism is also associated with harms to democracy itself—including the weakening of the free press,⁴⁴ the spreading of misinformation and disinformation,⁴⁵ and the influencing of elections.⁴⁶ Over the past 20 years, there has been a period of steady decline in democratic freedoms globally and a growth in surveillance and repression.⁴⁷ This trend coincides with the growth in surveillance capitalism and its profit incentives. Recent examples of intersections of surveillance capitalism infrastructure and the core of democracy include the actions of Cambridge Analytica, a data analytics firm that harvested information from 50 million Facebook users for a campaign to influence the 2016 US presidential election,⁴⁸ and another company that used AI combined with targeted advertising to mimic the voice of presidential candidates to try to mislead voters in the 2024 election.⁴⁹

It is important to understand that the ecosystem created by the surveillance capitalism business model is also a treasure trove for government surveillance, with state agents exploiting it to sidestep the Fourth Amendment⁵⁰ (which prohibits “unreasonable searches and seizures”⁵¹). Immigration and Customs Enforcement, the police, and federal intelligence agencies have trained their sights on the gargantuan stockpiles of personal information that technology companies have collected. Local and state

law enforcement agencies have consistently taken advantage of outdated state and federal electronic privacy laws to access personal information collected about who people are, where they go, what they do, and who they know.⁵²

To get a sense of the scale and impact of these government surveillance demands in the United States, in the first six months of 2025 alone, Meta was asked to turn over user information associated with more than 149,000 accounts,⁵³ and Google was asked to turn over user information associated with more than 120,000 accounts.⁵⁴ (Consider how much personal information about you, your family members, and your friends is in a *single* Facebook or Google account.) Most technology companies receive government surveillance demands, but it is impossible to know the true extent of electronic surveillance in the United States because the outdated federal electronic privacy law does not require reporting by the government, and only some companies, including Meta and Google, actually publish government transparency reports. The US government also buys regular access to information amassed by the multibillion-dollar data broker industry.⁵⁵

New AI tools are pushing these surveillance powers to even greater extremes. AI companies are the new boom, with existing technology giants incorporating AI into their products and other AI companies rushing to harvest incalculable amounts of information on people, either scraped from online sources or collected from how people use their services. The CEO of Anthropic issued a public warning in February 2026 highlighting that information the government can currently purchase can be used by AI to “assemble ... a comprehensive picture of any person’s life—automatically and at massive scale.”⁵⁶

With AI, History Is Repeating

As they did during debates about computerization in the 1970s, business interests today are recycling the same narratives about how AI can be used to benefit all of society while opposing any substantive regulation to ensure its power

will actually be used to help people and not just enrich a few.⁵⁷ Coupled with their ongoing anti-privacy blitz, companies are flooding our legislatures with lobbying money.⁵⁸ Big Tech has already surpassed all prior lobbying records, including Big Oil and Big Tobacco, with Amazon and Meta often topping the lobbying lists.⁵⁹ In the first nine months of 2025, the tech industry spent over \$50 million on federal lobbying—and Meta alone had one lobbyist for every six members of Congress.⁶⁰ The technology companies also lobby aggressively—and successfully—at the state level.⁶¹ Lobbying firms made \$92 million for AI-related work in the first three quarters of 2025.⁶²

AI tools are pushing these surveillance powers to even greater extremes.

On the federal level, these companies are working behind the scenes to try to pass a weak federal privacy law that could preempt and erase existing state privacy laws.⁶³ Tech lobbyists also show up at state capitols across the country to help steer efforts to pass weak state laws⁶⁴—and then return to DC to claim that federal preemption is even more necessary to address the growing “patchwork” of state laws.⁶⁵

When lobbying, companies are often using narratives⁶⁶ from a well-worn playbook: (1) they argue that technology and technology companies are inherently good for the world; (2) they claim that anyone who challenges technology is a backward Luddite; (3) they present technology and any potential uses of it as inevitable;⁶⁷ and (4) they describe technology as too complicated for nontech people to understand or regulate (a.k.a. the familiar “You’ll Break the Internet” argument⁶⁸).



In the current political climate and with exponential advances in AI, there is no more urgent time to learn from the past. The good news is that this time around, we the people are more attuned to what is truly at stake. According to 2023 polls, 82 percent of US voters do not trust technology leaders to tackle regulation independently,⁶⁹ and 77 percent of Americans “have little or no trust in leaders of social media companies to publicly admit mistakes and take responsibility for data misuse.”⁷⁰ In 2025, a supermajority—69 percent—of the US public said that they do not think the government is doing enough to regulate AI.⁷¹

Now is the time to work strategically on the local, state, national, and international levels to continue building the social movement necessary to put real power into privacy laws and make AI and other technologies work for the people.



How to Dismantle Surveillance Capitalism

If technology is going to work for the people, we cannot rely on weak procedural safeguards to protect us. Nor can we let technology be treated as an issue siloed from broader justice issues. Whether one works on labor rights, reproductive justice, education, racial justice, the climate crisis, immigrants’ rights, or any other issue, the ultimate success of these fights for justice depends on passing laws that protect and advance rights in the AI age.

1. Protect Current Protections

The first, most concrete step is to protect current protections. We must not allow the federal government to enact any federal AI or privacy law

with preemption (a provision that stops states from enforcing current laws or passing new ones). Several bills have already been introduced at the federal level that would broadly preempt the efforts of state governments to protect people’s rights and safety. Preemption of state law is the holy grail for technology companies that want to erase current state laws and bottleneck any additional progress on regulating technology generally and new AI systems more specifically.

Congress has historically given states room to enact stronger laws—and for good reason. Technology can advance quickly, and Congress often moves slowly. States serve a particularly critical function in areas of law as rapidly evolving as new technology. For example, the California constitutional right to privacy still has untapped potential and can be a crucial sword to combat corporate and government surveillance excesses.⁷² By barring continuing and efficient attention to the issue, preemption would freeze the current regime in place. The current presidential administration has been pushing for preemption through executive orders and other political pressure.⁷³

Any federal AI or privacy law must be a floor, not a ceiling. States must be free to enforce existing laws and continue to enact new privacy laws that are stronger than any federal baseline. While many state leaders and a broad coalition of organizations are fighting back, more help is needed to stop federal preemption efforts in their tracks and to continue at the state level to address surveillance capitalism and protect people.⁷⁴

2. Pass Robust Laws That Get to the Core of Surveillance Capitalism

The second step is to build power to support and pass robust, baseline consumer privacy laws that protect people in the AI age. Policymakers need to move beyond “wet napkin privacy laws”⁷⁵ that rely on faulty notice and consent, placing “the burden of protection from commercial surveillance ... mostly on us.”⁷⁶ Instead, they need to pass new, substan-

tive privacy laws that flat-out prohibit certain ways that information is collected and can be used. Passing these new laws is the best step to address the downstream effects of surveillance capitalism on our lives and health, rights, and democracy.⁷⁷

3. Center the People in AI Decision-Making

There must also be substantive laws that create robust rules for AI, not just weak process safeguards that do nothing to address power structures. It is critical that more diverse coalitions work together to enact laws that center people, not profit, in how AI is developed and used. Decision-making about AI systems used by both government and business must be grounded in fairness, accountability, evidence-based inquiry, and inclusive governance so that the power of AI can be wielded for the people.⁷⁸

AI use is growing in the private sector, and many government agencies have already deployed or are considering using AI in consequential decisions related to healthcare, housing, education, policing, finance, and other highly sensitive areas. While some policymakers have taken steps to implement decision-making mechanisms for certain AI systems, too many leaders simply accept corporate narratives about AI’s purported public benefit at face value. They are jumping to the “how” of AI implementation before thoroughly vetting potential systems or considering the “why” and “whether” to use AI systems at all. The people who are most impacted need an active role in decision-making, and some uses of AI need to be off the table completely. AI should never be trusted to make high-stakes decisions in our criminal, immigration, and policing systems, so one important place to start is prohibitions on its use for face and other biometric surveillance systems.

4. Engage in Surveillance Self-Defense

We should all use available tools to protect ourselves and safeguard our personal information from collection and use.

Now is the time to put real power into privacy laws and make AI and other technologies work for the people.

- Use privacy-protective tools like Privacy Badger, an easy-to-use browser add-on that stops advertisers and trackers from secretly tracking where you go and what pages you look at on the web. Privacy Badger is developed and made available by the nonprofit Electronic Frontier Foundation,⁷⁹ which provides many other guides and no-cost resources to help you with surveillance self-defense.⁸⁰
- Learn about state laws that you can use to protect your personal information. For example, if you live in California, take advantage of the California Consumer Privacy Act to learn what personal information companies have collected about you and to delete your information from company databases.⁸¹ Use the California Delete Act and the state’s new Delete Request and Opt-Out Platform as a one-stop shop to delete your information from data brokers and stop them from selling your information to others.⁸²

The future of American democracy has become more and more imperiled since the rise of surveillance capitalism. Now, the rapid growth of AI is supercharging the power of government to pursue an anti-rights agenda. In the current political climate, the stakes are higher than ever to come together to enact the laws and policies that will make technology work for the people and allow us to advance rights, justice, freedom, and opportunity for all. ✦

For the endnotes, see aft.org/hc/fall2026/azer.

Rural America May Be Ground Zero for Health System Reform



By Jeanne M. Lambrew

Healthcare has been a dominant issue in US public policy debates in 2026. This mirrors surveys that have found healthcare access and affordability are Americans' top worries.¹ Nearly two-thirds of households reported being concerned about paying for healthcare expenses, more than those with

concerns about food or rent expenses.² Other healthcare worries include access to primary care, navigating the complicated system, and corporate greed. There is a general sense that the health system is broken,³ spurring interest in major reforms.

The work to reform the US health system may—and arguably should—start in rural America. Longstanding, entrenched challenges face the roughly 46 million people living in remote places. These challenges have been exacerbated by health system consolidation and corporatization, facility closures,

labor trends, and recent federal funding cuts. Rural residents and the clinicians who serve them will command attention from policy officials in 2027, no matter the outcome of the midterm elections.

This article reviews the health policy landscape, the status of the rural health system, and prospects for long-run and immediate policy changes. It does so from the author's perspective of over 20 years in government service, including in a rural state. As such, some of its content is speculative based on experience rather than research. It focuses primarily on health services and less on behavioral health, public health, or long-term services and supports.

The Current Health Policy Landscape

Throughout most of the 20th century and the beginning of the 21st, leaders at the federal and state levels were able to take strides toward a universal, affordable, high-quality health system. For example, Medicare and Medicaid were enacted in 1965, patient protections and children's coverage advanced in the 1990s, and the Medicare drug benefit was launched in 2006. Massachusetts enacted its health reform law in the same year, which resulted in 98 percent of its residents having health insurance. In the words of current governor Maura Healey and former governor Mitt Romney at a 20th anniversary event, "It was a tangible demonstration of what is possible when leaders of all perspectives come together, set aside partisanship, and focus on solving real problems."⁴

However, consensus on health system goals has become elusive in the last two decades. In drafting the Affordable Care Act (ACA), President Obama and legislative leaders adopted the broadly supported Massachusetts approach of a largely private insurance system with heavy government regulation and financial support, funded with spending reductions and new taxes. Congress accepted hundreds of bipartisan amendments, and Obama held a summit

with Republicans to get their input. Yet virtually no Republicans voted for its final passage in 2010, and partisan efforts to challenge and repeal it began immediately.⁵

The work to reform the US health system may—and arguably should—start in rural America.

The retreat from compromise has contributed to sharply divergent visions for health reform. According to conservatives, affordability can be achieved by providing catastrophic coverage and cash to people to shop for care.⁶ Liberals would, in a 180-degree turn, move more healthcare responsibility to the government to set prices via a generous Medicare for some (i.e., a public plan extension or option)⁷ or Medicare for all system.⁸ People on the right believe health coverage is an earned benefit; people on the left view it as a common good. While all agree that the United States spends too much on healthcare, there is a partisan divide on whether the government share of that spending is too high or too low. This is not surprising in a legislative environment in which change occurs primarily when the winner takes all. A simple, strident message may be more effective at generating voter enthusiasm than a pragmatic or bipartisan approach to solving problems.

At the same time, even unitary control of Congress and the White House hasn't enabled either side's partisan vision to be fulfilled. In 2021 and 2022, Democrats empowered Medicare to negotiate drug prices and improved premium tax credits—but did not succeed in extending coverage to poor people in states that had not expanded Medicaid or adding hearing, vision, or dental benefits to Medi-

care. In 2025, Republicans reduced federal health spending by an estimated \$1 trillion over the next decade—but did not repeal the ACA or block-grant Medicaid. Why? Because even within each political party, legislators, advocates, and other stakeholders do not fully agree on their goals. Within-party differences are common, which perhaps ought to be expected since neither political party has had more than a 10-percentage-point advantage among voters since 2008.⁹

This dynamic has consequences. Without national health policy that is cohesive and adaptable, health spending as a share of the economy, which stabilized in the years after the ACA's passage,¹⁰ has started climbing again.¹¹ The government has neither effectively checked consolidation in the health sector nor protected consumers from contract disputes between insurers and health systems.¹² Furthermore, it has not slowed the rise of private equity,* which transfers resources from the health system to investors.¹³ Attempts to close loopholes have led to a patchwork of complexity that has itself created barriers to seeking and providing

healthcare. And distrust of government has escalated.¹⁴

The Rural Health System's Slow Demise

Rural residents experience more barriers to affordable, accessible healthcare than most other Americans. Some of this reflects broader trends. Today, fewer counties are classified as rural than in the middle of the last century, and fewer residents remain in counties still classified as rural. Young adults have moved away, raising the average age of residents who are left; rural deaths increasingly outnumber births.¹⁵ This demographic shift contributes to higher rates of overall mortality as well as potential excess deaths from heart disease, cancer, unintentional injury, chronic lower respiratory disease, and stroke.¹⁶ But that's not the whole story.

Rural health outcomes also reflect relatively low supply. Nearly all rural counties have a federally designated health professional shortage area. Geographic access to primary care physicians is lower for rural than nonrural residents.¹⁷ So, too, is telehealth use: Only 19 percent of rural residents receive primary care via telehealth compared to 31 percent of nonrural residents, likely due to inaccessible or unaffordable high-speed

internet or broadband.¹⁸ Clinicians specializing in behavioral health, dental, and obstetrical care are more likely to practice in urban than in rural areas. Travel staff have become ubiquitous in filling in gaps—and driving up costs. That said, the numbers of nurse practitioners and physician assistants have been growing in rural areas.¹⁹ About 90 percent of rural counties had either a rural health clinic or federally qualified health center in 2021.²⁰ And healthcare clinics and facilities for Native populations and veterans dot the rural landscape.

Alongside population declines, rural hospitals and nursing homes have been closing. Between 1990 and 2020, 334 rural hospitals closed,²¹ and 43 additional rural hospitals have closed since 2020.²² Since 2011, hospital closures have outnumbered new hospital openings.²³ Compounding the problem, since 2019, nationwide nursing home operating capacity has dropped by 5 percent (effectively 4,000 fewer available beds each day), with 25 percent of rural counties experiencing a decline of 15 percent or more.²⁴ Lack of rural nursing facility beds often means hospitals struggle to discharge older patients in need of step-down care, further straining their capacity.

Rural providers tend to charge lower rates and be reimbursed for services at lower rates than urban providers²⁵—and expenses like median salary per full-time equivalent are lower for rural hospitals than urban hospitals.²⁶ In spite of this, premiums and out-of-pocket costs tend to be higher for rural than urban residents. Higher premiums result from fewer choices and higher fixed costs (e.g., staffing low-volume facilities, transportation) as well as the greater health needs of older populations and those with lower incomes in rural areas.²⁷ Higher out-of-pocket costs reflect a lower rate of employer coverage and higher rate of uninsurance among rural residents.²⁸ Rural workers are often self-employed or small business owners, resulting in a greater use of the ACA Health Insurance Marketplaces for cover-

age. Additionally, one in four rural residents is enrolled in Medicaid, reflecting poverty in rural America.²⁹ This translates into cost-related access problems, which are reported by 62 percent of rural residents, compared to 56 percent of nonrural residents.³⁰

Rural residents experience more barriers to affordable, accessible healthcare than most other Americans.

Against this backdrop, recent changes have exacerbated rural health system problems. Supply chain costs due to tariffs and transportation costs due to higher gas prices are disproportionately borne by rural facilities. Immigration policy change has also had a swift impact. One in three home care workers and one in five nursing facility workers are immigrants.³¹ Increased detentions, mass deportations, and interior raids by Immigration and Customs Enforcement (ICE) have resulted in increased staff call-outs in some areas, putting patient care at risk.³² Additionally, 14 percent of rural physicians and surgeons were naturalized citizens or noncitizen immigrants in 2023, three times their share of the total rural population.³³ The Trump administration's \$100,000 fee for H-1B petitions and freeze on visas, renewals, and other work permits for people from roughly 40 countries are already straining systems that have relied on these professionals.³⁴ At the same time, the administration finalized a rule that denies higher student loan limits for advanced nursing degree students³⁵—a move that will make it harder for US citizens

*To learn more, see "How Private Equity Has Looted Our Hospitals" in the Fall 2024 issue of *AFT Health Care*: go.aft.org/q19.





to prepare to fill the void being left by foreign-born clinicians. While such policies are in flux (for example, the H-1B fee was successfully challenged in court, but the administration is appealing³⁶), their chilling effects are real.

Moreover, 2025 congressional action, specifically the One Big Beautiful Bill Act (OBBBA), and inaction have begun to affect rural healthcare. Due to Congress's failure to extend enhanced premium tax credits, rural residents are paying on average twice as much for Marketplace premiums in 2026 than 2025, with their average increase being 28 percent higher than that of urban residents in federally run Marketplaces.³⁷ And stricter Marketplace eligibility and redetermination system changes are on the horizon, pushing premiums even higher.³⁸

In addition to Marketplace changes, the OBBBA has over 20 changes to Medicaid, including the addition of a community engagement requirement (a.k.a. work requirement) starting in January 2027.³⁹ Some of those changes, like limits on how states finance Medicaid, will result in reductions in payments, benefits, or eligibility beyond what is in the OBBBA.⁴⁰ The Medicaid parts of this law are projected to reduce federal Medicaid spending in rural areas by \$137 billion from 2025 to 2034.⁴¹

Considering the Marketplace and Medicaid changes together, the Congressional Budget Office estimates the law will reduce nationwide federal health spending by over \$1 trillion over the next decade, primarily by shrinking the number of people who can access healthcare: A projected 15 million more people will be uninsured in 2034.⁴² Experts project that over the next 10 years, rural hospital revenue will be lowered by an estimated \$87 billion and uncompensated care will increase by \$23 billion.⁴³

In an acknowledgement of its rural impact, the OBBBA includes a five-year, \$50 billion Rural Health Transformation Program. However, its amount, allocation, and strict rules on usage limit its likely impact.⁴⁴

Long-Run Prospects for Major Health System Change

Slow-growing problems combined with recent shocks help explain why a record-high percentage of Americans believe the healthcare system is in crisis.⁴⁵ Efforts to solve long-standing and escalating issues like consolidation, corporatization, and complexity are overdue. The destabilizing effects of recent policy changes, some of which are soon to take effect, have added urgency. Together, they are catalyzing a climate for the

type of sweeping change that occurred with the passage of Medicare, Medicaid, and the ACA—all of which necessitated presidential leadership.

Healthcare does not rank as high an issue among Republicans as among independents and Democrats.⁴⁶ The current president neither campaigned on nor prioritized health reform, instead focusing on purported healthcare waste, fraud, and abuse, and the Make America Healthy Again agenda. His one-page health reform plan supports lowering drug prices and giving government funds directly to people (rather than insurance companies) to shop for health services.⁴⁷ The Republican-led Congress has yet to effectively act on such proposals. The next Republican presidential nominee is likely to adopt President Trump's plan since early frontrunners are either in his administration or are governors supporting him.⁴⁸

On the Democratic front, it is likely that the 2028 presidential nominee will have a bold plan, although it is too early to predict what it might include. That said, three themes connect the range of emerging proposals. The first is a more robust role for government, which is in part fueled by anger at for-profit and consolidated health insurers, providers, drug manufacturers, and others.⁴⁹ Nearly two-thirds of US adults in a recent survey said government should make sure all Americans have healthcare.⁵⁰ Among Democrats or people leaning toward Democrats, most support a single national government program such as Medicare for some or all. Others prefer a mix of government and private programs, which has emerged in recent proposals.⁵¹ Relatedly, policymakers are considering ideas for preventing and breaking up consolidated systems⁵² and for replacing private equity and system ownership of practices, clinics, and hospitals with publicly backed options.⁵³

A second emerging theme is simplification.⁵⁴ Complexity creates barriers to care and opportunities to increase profits in the health system.⁵⁵ One idea gaining traction is

standardizing cost sharing, benefits, provider contracts, and insurance processes across programs.⁵⁶ Others would tackle parts of the care spectrum, such as making primary care free of cost sharing⁵⁷ or financed through a common fund, like a public utility.⁵⁸ Making the system easier to navigate would improve patients' and clinicians' experiences as well as accountability and oversight, driving out some expensive loopholes and unnecessary administrative costs.

The third theme that is likely to characterize future health reform proposals is credibility. People seem to prefer discrete, achievable policies like a \$35 monthly cap on insulin copays to more beneficial yet abstract policies like blocking health system mergers. This makes sense at a time when results are desperately desired and trust in government is near a 70-year low.⁵⁹ Health reform proposals likely will have to be of the "show me" variety to avoid being dismissed as empty promises.

Over the next 10 years, rural hospital revenue will decrease by an estimated \$87 billion.

What does this mean for healthcare providers in the rural United States? Under a Republican president in 2029, the current state of rural health systems would likely continue on its current path with changes at the margins. Under a Democratic president, successful health reform may yield government, rather than private, investment in rural brick-and-mortar health facilities, broadband access to telehealth, the workforce, and coordination and transportation in regional systems of care. Potentially, under a Democratic

reform plan, the government would heavily regulate and standardize private insurance or run a Medicare-like public health plan that would improve affordability for the families of rural farmers, small business owners, and older residents disadvantaged by the current insurance system. Simplification of reimbursement systems could yield capitated,* all-payer payments for critical services to ensure rural residents have timely and affordable access to services like maternity and emergency care. A likely change in support for legal immigration could result in a return of new Americans to rural communities to support residents' health.

Envisioning an effective rural health system now will help shape such policies.

Short-Run Possibilities to Advance Health Reform

The race for the next presidency begins the day after the 2026 midterm elections. In the meantime, if healthcare concerns contribute to Democratic gains in the midterm elections, opportunities to advance health reform could arise in 2027. The caveat is that divided gov-

ernment typically results in gridlock rather than compromise. It is unlikely that Trump would either sign Democratic-led bills or change his health reform plan.

Still, one opportunity for improvement would be oversight and interrogation of health system problems. A reform-oriented majority in the House or Senate could hold hearings, produce reports, schedule votes and resolutions, and otherwise use its authority to further define health system problems. This would go beyond vague claims that "the system is broken" and "healthcare is unaffordable" to deeply explore and develop a consensus on the root causes to begin a meaningful dialogue on potential changes. This is especially important given extensive lobbying and the many ways that complexity enables finger-pointing: Drug companies blame hospitals, hospitals blame insurers, insurers blame providers, and Americans blame politicians. Change is difficult; one stakeholder's savings is another stakeholder's profits. And voters often opt for the flawed system they know instead of a changed system built on promises. And yet, since healthcare affordability truly is a worsening crisis, concerted congressional leadership could yield a consensus on key health system problems from which solutions may flow.

*To learn about capitated payment models, see "COVID-19: From Public Health Crisis to Healthcare Evolution" in the Fall 2020 issue of *AFT Health Care*: go.aft.org/1nu.



In 2027, regardless of midterm election outcomes, Congress may also be a testing ground for pragmatic policy solutions aimed at simplifying the system and improving healthcare affordability. Some proposals could be nationwide. For example, Congress could advance proposals to remove insurers from prior authorization decisions⁶⁰ or eliminate ACA plan deductibles by restoring the cost-sharing subsidy payments that were stopped by the first Trump administration.⁶¹

Other short-term proposals might focus on rural areas—ground zero for health system challenges. At the top of the list is allowing the Rural Health Transformation Program to pay for hospital and clinic services for rural people falling through the cracks; the Trump administration arbitrarily limited that amount to 15 percent of the total funding.⁶² Additionally, Congress could nationalize a simplified payment model like the Pennsylvania Rural Health Model, in which Medicare, Medicaid, and certain commercial insurers pay participating hospitals a fixed amount up front regardless of patient volume, allowing the hospitals to make strategic investments in their communities' healthcare needs.⁶³ It could also restore and expand funding for the rural healthcare workforce and supports, as well as delay or repeal recent changes to Medicaid and the ACA that disproportionately affect rural America.

A strong midterm message from voters to Congress to act on healthcare affordability, especially in rural areas, could defy the odds and result in successful legislation in 2027. This would provide proof to the growing number of skeptics that government can work. Alternatively, stalemates and stagnation could continue, increasing Americans' anger and fueling a demand for wholesale change in the 2028 elections.

Despite recent and current challenges, this nation has proven it can take collective action to advance healthcare. Effective policies contributed to a record-low unin-

sured rate in 2023 and 2024⁶⁴ and a pause in the growth of health spending as a share of the economy after the ACA was enacted.⁶⁵ They also contributed to making health jobs 12 of the top 20 fastest-growing professions.⁶⁶

Ingenuity can be found across the rural health landscape. Examples abound: Community paramedicine programs are flexing paramedics and emergency medical technicians to assist in home visits and chronic care management in Minnesota and Maine.⁶⁷ Community health workers are connecting health, public health, and other services in rural Kentucky.⁶⁸ Independent rural hospitals in North Dakota and other areas have formed a clinically integrated network to coordinate services and pool resources.⁶⁹

We need achievable structural improvements in the near term and a bold, shared vision for our health system.

At a time when policy action and inaction are stressing rural residents and their clinicians, advocacy for patches, targeted assistance, and a "do no harm" approach is necessary but not sufficient. Catalyzing structural, achievable improvements in the near term will help rebuild trust that government can successfully support broader systemic reform. And developing a bold, shared vision for what our health system should deliver and how—starting in rural America—will inform the next major reform of the US health system. Rural health professionals can help shape that future. ✦

For the endnotes, see aft.org/hc/fall2026/lambrew.

Nurturing Trust and Equity in Patient Spaces



By George Rust

I grew up in one world, but I've spent most of my life working in another. I grew up in white-world, where everyone looked like me and spoke English. From birth to medical school, I lived in a world where our white Anglo norms were society's norms. Other people's perspectives were "ethnic" or "cultural." Our sense of "normal" set the boundaries between us and others. And then the boundaries moved. Or I moved.

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There came a moment when I decided that I needed to make a difference in the world. My own insecurities, my family dysfunction, and my college roommate's suicide all left me questioning my choices and my value as a person. All I had was this vague, poorly defined sense that I wanted to help people, especially the people who needed help most.

So, I moved. I switched first from being an English major at Harvard to being a premed chemistry major at the University of Miami. I learned about yogurt and Boston accents and arrogance at Harvard and about Cuban coffee and Jesus at the U.

Today, America is in transition. A white-majority population accustomed to setting the norms is moving into a new minority-majority reality. I've lived and practiced amidst this transition in urban Chicago and in the small-

town Deep South. In Chicago, I worked with immigrant doctors at Cook County Hospital and immigrant patients at our South Lawndale/La Villita clinic. In the 1980s in Central Florida, I served six years as medical director of the West Orange Farmworkers Health Association. I practiced in our smallest migrant clinic, on Highway 50 in Groveland, Florida. I did home visits on dirt roads on the Black side of town.

I moved from Groveland to Atlanta, to the then-relatively new Morehouse School of Medicine. It took a quarter century of working in a historically Black medical school to help me find my soul, to make peace with myself, and in some ways to become comfortable in my own skin.

In my current faculty position at Florida State University, I am a teacher, a researcher, and a tenured professor; I also chaired the Council on Diversity and Inclusion (now the Council on Engagement) at our College of Medicine. But I am outlawed from teaching that systemic racism and institutionalized inequities are root causes of health disparities. As a

public health physician, I am not supposed to promote vaccinations that could save lives. By order of the state surgeon general, no one in the Florida Department of Health is *ever* supposed to use the phrase *health equity*. To say it would require us to acknowledge that we still have systemic *inequities*. My colleagues and I are also handcuffed in the care we may provide to trans individuals or even to women making reproductive choices.

Here's the dilemma for white people who want to do the right thing and be on the right side of history. How do we come to grips with our own whiteness? For many of us, the opposite of being a white nationalist has meant

denying race or pretending that we live in a post-racial world. We have good intentions. But to deny our own racial identity or pretend that we don't see race is to gaslight the real everyday lived experience of people of color. It also denies our own lived experience of privilege.

But I wonder—is there a third path, one that boldly rejects white nationalism or white identity politics but also avoids the color-blind racism of claiming that race doesn't matter? Over the past few decades, I have paid attention to my own journey attempting to forge this "third path." I have tried to encourage others to see their own true selves, including their own whiteness, through nonwhite eyes.

I see the dysfunction, and I wonder how and when the healing can begin.

A critical realization was that I had a radically different perspective on trust, and on respect, than my Black colleagues.

The march of progress is often slow and uneven, two steps forward and sometimes two steps back. But it marches on. Changing demographics are driving us forward. Communicating openly about who we are as diverse humans is driving us forward. The complexity of modern families is driving us forward. Civil rights advocates and social

justice warriors and democratic socialists and allies and woke people are all leading us forward. And the status quo, anti-woke, shrinking minority will have the same experience as all those who came before. They will live to see the progress. Perhaps one day they may see this brave new world as an opportunity for learning and growth. It is our moment for both giving and receiving love and grace. It is our moment for healing. If we so choose.

At Morehouse, one way that I found healing was by striving to understand racial and cultural differences that impact healthcare. A critical realization—that came to me much too slowly, over several years—was that I had

a radically different perspective on trust, and on respect, than my Black colleagues. While I delve into many more cultural differences in my book, *Healing in a Changing America*, here I share how I learned to earn my patients' and colleagues' trust.

Questioning My Trustworthiness

"Why should I trust you?" she asked. I was shocked and hurt and offended all at the same time. *What had I done?*

I had recently taken a leadership position as medical director of the Morehouse Family Practice Center, where she was a nurse educator on the clinical faculty. To give context, the older physicians on faculty were all Black, while the recent hires (including me) were white. The nurses were all Black women. The front desk staff were all Black women. The nonphysician faculty (nutritionist, psychologist, etc.) were all Black women. A new, young white-guy physician (me) had been put in charge of the clinic. To a small extent, I had been given control over my colleague's schedule and her workload.

The instinct to distrust a white man with power was deep and visceral. It was a distrust that had been earned by many white men in positions of power before me. It was distrust built up over generations and reinforced almost every day. Of course, people of color shouldn't give their trust freely to white people. Let white people earn it. Do I frame the problem as hers, as a problem of her distrust? Or is it my challenge for me to become and to be known as trustworthy?

This was the beginning of a new insight that took a while to grow. I had done nothing to lose her trust, but I also had done nothing to

gain her trust. I was starting from an assumption that trust was something I already had but could lose if I behaved badly. She (and many of our colleagues of color) started from an instinct of caution and skepticism. Some scholars call it "a hermeneutic of suspicion."¹

Mistrust was the logical conclusion of knowing that they've been burned too many times before. Think of all the historic reasons to mistrust white people. Start from slavery. Move on to Jim Crow oppression to lynchings to race massacres² to voting suppression (then³ and now⁴). Think of redlining in housing⁵ and of employment discrimination.⁶ Wrap your head around the massive attempt to dehumanize African Americans. Think about it in healthcare, from torturous surgical experiments on enslaved people⁷ to the psychological diagnosis of "runaway slave

syndrome."⁸ We segregated hospital wards⁹ and doctors' offices.¹⁰ We ran government-funded syphilis experiments.¹¹ We still have disparities in treatment for pain¹² and cancer¹³ and heart disease.¹⁴ Then multiply those by a thousand demeaning experiences and microaggressions that people of color experience every day.¹⁵ Why should they trust me?

At Morehouse, I had to work to earn the trust of patients and staff and fellow physicians. In many ways, this trust/distrust dynamic was the opposite side of the respect/disrespect coin in how we related to each other. My colleague's unwillingness to start from a baseline of trusting people she didn't know was similar to how I thought people should have to earn my respect. Her assumption was that showing respect to all people was a given. Showing disrespect was an assault on one's humanity. It was fascinating to me in that moment when my trust was questioned

that neither of us was aware of how the other perceived issues of trust/distrust and respect/disrespect. We had polar opposite racial and cultural lenses.

This trust/distrust dynamic plays out in medical care every day. It manifests as one of the many root causes of unequal health outcomes. There is a growing body of research designed simply to find valid measures of the various domains of trust, including trust in physicians, trust in institutions, and more generalized cultural mistrust.¹⁶ Unfortunately, much of this research blames patients by framing the issue as a problem of "those people," of the minority group. Much less research has been devoted to the measurement of white trustworthiness or institutional trustworthiness.¹⁷

Personal, Relational Trust

Early in my career, I joined the medical staff of the West Orange Farmworkers Health Association, caring for patients in the smallest, most remote clinic. Groveland, Florida, was a town with two stoplights, no Dairy Queen, and a dark history of racial animus. My patients were not just farmworkers but also low-income and uninsured people of

all backgrounds. Maybe a third were African American, a third white, and a third Hispanic or Latine. Our other clinics served Haitian and Chinese immigrants as well. All too often, my heart was broken by seeing preventable suffering. We saw late-stage cancers (as described in "The Need for Healing" on page 60) and extreme complications of treatable diseases that doctors serving the well-insured and well-off rarely saw. Sometimes the barriers were financial or structural and sometimes cultural or psychological. Sometimes the barrier to getting the right care was mistrust.

Patients who have more trust in their healthcare professionals are more satisfied with their treatment, have fewer symptoms, and pursue healthier behaviors.¹⁸ Patients see nuance and have a keen sense of whom to trust. For example, one group of researchers found that people might mistrust white Anglo doctors and even the whole healthcare system but still trust their nurse practitioner.¹⁹ Maybe doctors should put on our humble hats and learn about building trust from our nursing colleagues. Nurses are often more competent in relational skills. (Sadly, medical schools do not select future doctors for their emotional intelligence.)

The power dynamics are also different for nurses than for doctors. Power and control are central to issues of white trustworthiness. As physicians, especially white-guy physicians, we must give up the need to control. Instead of the

usual push-pull of trying to get my patient to make the healthy choice (i.e., what I want them to do), I've learned to practice my motivational interviewing skills. I come alongside my patient and see the world through their eyes. I walk with them toward their goals, not mine.

When I took over as medical director of all the clinics in the association (mere months

after starting), my predecessor took me out to lunch. Dr. Otilia Mariña is an incredibly dedicated family physician. I think she was worried that I didn't quite get it. As we were eating, she tried to pass along some of her passion and wisdom. "George," she said, *"when I'm in the exam room with a patient, they tell me things they wouldn't even tell their spouse or their best friend."* She paused. *"I feel like a priestess."* There was a sacredness in this moment as well. She went on. *"Sometimes I can't fix it. But all they expect, all they hope for, is that I will hold their hand and walk with them on their jour-*

Patients who have more trust in their healthcare professionals pursue healthier behaviors.



ney.” I don’t know if I ever got it in the same way that Oti did, but I took it all to heart. I share her words with every class of medical students that comes my way.

In Groveland, the Latine community we served in our migrant/community health center was mostly of Mexican origin. We saw out-of-control diabetes every day. And we saw all the long-term consequences of high blood sugars and poorly controlled diabetes. Working in this community taught me one thing about helping people manage their own health. *It’s relational, not informational.* It’s about dignity and respect. It’s not about facts or graphs or data. Instead, it’s about personal, relational trust. Our front desk team comprised wonderful young women who had grown up in the community and had only a high school education. They were part of the extended families of many of our patients. If I couldn’t be trusted, at least I could build a team that had trust. I could be trust-adjacent. These were the core values. *Familismo. Personalismo. Respeto. Confianza.*

Earning Trust

In a Hastings Center Report, Laura Specker Sullivan, a philosophy professor who studies trust, writes: “For those who have faced exploitation and discrimination at the hands of physicians, ... and medical institutions, trust is a tall order and, in many cases, would be naive.”²⁰ Our task is not just to get patients to trust us but to become trustable. In Sullivan’s words, we face the daunting task of “establishing trust in an unjust environment.”²¹ This is a key point. If we frame this as a problem of Black or African American mistrust,²² we are getting it wrong. The problem is the white failure to be trustworthy, played out over centuries. It gets repeated in healthcare settings and



communities every day. White untrustworthiness breeds Black mistrust. The Association of American Medical Colleges recently released its 10 “Principles of Trustworthiness” to guide community engagement.²³ They tell us to stop trying to educate the community. In fact, their first principle is that “The community is already educated; that’s why it doesn’t trust you.”

We begin to make progress when we are willing to do the hard work of dismantling the untrustworthiness of historically white institutions and of white people. I earn trust when I honestly acknowledge a historic pattern of abuse and bias that is still present.²⁴ I earn trust when I see things through the eyes of minoritized patients and colleagues. I earn trust when I acknowledge (and repent of) my own easy acceptance of white privilege. I have to own

the fact that I still benefit from systems that favor me. I earn trust when I seek to change my own implicit and explicit biases and prejudice. I earn trust when I find my voice and overcome my own silence in the face of inequity.

If I’m just a white guy trying to avoid race and treat each patient as a unique individual, then I am discounting others’ racialized experience. I am pretending that race doesn’t matter, while they experience the abuse of racism every day. And if my healthcare system is producing racially unequal outcomes, I need to own it. Either it has structures and processes that bias those outcomes, or else somehow the victims are to blame for all the inequalities they experience.

Individual “cultural competency” is not enough. We must diagnose and fix the brokenness. Can you say the word *racism*? Can you say it out loud in front of your peers or your leadership? If not, can you at least have prac-

tical, strategic, and tactical discussions about actions to eliminate bias and discrimination? Can you strategize on how to reverse power/resource inequities and health outcome disparities? Can you make a long-term commitment to actively engage in antiracism action? If not, why should people on the receiving end of racial inequities trust you?

How do patients experience racism in your clinic or hospital? Ask them, but be ready to act on what you hear. Have the right person ask them, in a setting where it is safe to express true feelings, including pain and rage. Dig into the hard, marathon work of undoing racism in your organization or practice.* What would it take to achieve perfect equality of outcomes across all racial/ethnic/gender and socioeconomic strata of patients? What would it take to achieve vertically proportionate diversity, with minorities oversampled in positions of leadership and power and budget authority? The days when organizations can just hire a VP for Diversity are long past.

Can we teach doctors and nurses and healthcare executives to do better? The jury is still out. In one review of interventions designed to enhance patient trust, researchers found no effect.²⁵ Clearly, short-term cultural competence workshops are not enough. We might raise awareness, but building trust requires a deep soul commitment to being trustworthy. It means acknowledging racism and injustice while using our privilege to confront the root causes of inequity.

So how can a white guy earn trust in a non-white world? Trust is earned every day in the

interactions that show respect or disrespect. Trust is earned in learning to offer that respect in the form and manner in which each person receives respect. These may be quite different from the ways in which I would feel respected. And when trust is given before we’ve earned it, we must honor that gift as an act of grace.

Many of us are not in charge of anything. We feel like we have no power to make justice blossom. But where we do not have control, we often have influence. We can speak up when we see injustice. We can ask the naive question: How could we make things better? We can reflect bias or ugliness back to the speaker: “*What did you mean when you said that?*”

We can stand with those who have authentic lived experience or who are effective advocates for their community. We can notice when hierarchy or systems of power or a culture of denial are making it too risky for them to speak up. In those moments, we can step into that danger and speak as an ally.

Imagine thousands of us across this country and millions around the world committed to nurturing gardens of equity in all the spaces we touch. Imagine those vibrant, colorful gardens becoming the ecosystem of our nation and injustice merely the weeds that we must occasionally dig out.

Wouldn’t that be worth doing? Wouldn’t you want to play your part? We don’t have to be perfect. We just have to do our best to grow and tend the garden. And we have to be intentional. +

**Our task is not just
to get patients to
trust us but to
become trustable.**

*For guidance on how to undertake this work, see “Brave Spaces: Community-Driven Anti-Racism Partnerships” in the Fall 2021 issue of *AFT Health Care*: go.aft.org/yby.

For the endnotes, see aft.org/hc/fall2026/rust.

The Need for Healing

In 2018, healthcare economists estimated that the cost of illness and premature death due to racial disparities nationwide was at least \$421 billion every year.¹ It costs taxpayers money to allow preventable suffering. It would save money to do it right.² Why don't we?

Stalin supposedly once said that "one death is a tragedy; a million deaths is a statistic." As a health outcomes researcher, I know the statistics. As a family doc serving low-income and uninsured people, I know the tragedies. Cervical cancer, for example, is rarely seen at advanced stages in white, well-educated, well-insured patients. Once the Pap smear was widely adopted, cervical cancer went from being a leading cause of death for younger women to being a preventable, treatable condition.



One evening, I was called to the emergency department to see one of my patients who was having profuse vaginal bleeding. She was from the dirt-poor enclave of Stuckey Still, once an old turpentine work camp outside of Groveland. The emergency physician thought she might bleed to death. She had been previously diagnosed with cervical cancer and treated with radiation implants by a specialist in Orlando. Perhaps because

our patient didn't have good insurance, the GYN oncologist refused to have her transferred to the larger specialty hospital. "I don't really have anything else to do for her," he said blithely. "Just pack her with gauze and maybe get her some hospice care."

I examined her gently. With a lighted speculum, I tried to see past the blood that was pouring out. A normal cervix looks a bit like the tip of a nose, pink and round with a small hole at the center. Instead, I saw what appeared to be a huge white rotting cauliflower mass where her cervix should be. Blood was leaking from multiple sites. What the hell could I do? I'm not a surgeon, and none of the specialists wanted to help me.

I ordered blood transfusions to replace the blood she was losing so quickly. I packed sterile gauze up against the bleeding cancer. I kept packing until the vaginal canal was full of bloody gauze, hoping that the pressure would stanch the bleeding.

I spoke gently with my patient. "You know what's going on?"

She nodded. "I got the cancer last year and they put the radiation seeds in me. But they said it was pretty far gone. I never had the Pap smear. Never really went to doctors at all...."

I paused to let the wave of grief and sadness pass over me. "The specialists, they say...." I stumbled for words.

"I know," she said, trying to comfort me more than I was comforting her.

I felt inadequate and powerless and sad. "I've done everything I know how to do. We'll

keep you here tonight and see if we can get the bleeding to stop." We both knew how this would end if we couldn't.

She expressed her faith in God and her sense of peace, whatever the outcome might be. My faith was a lot less adequate. We held hands for a bit, as I tried to give her my spirit and my compassion, even as she gave me her strength.

The next morning (a few hours later really), I came back to the hospital to check on her. The bleeding had stopped. Her blood count had stabilized with the transfusions. Later that day, we changed the packing. With old clots of blood came pieces of the mass, the cancer that was trying to kill her. She was having a late response to the radiation. The cancer was dying more quickly than the patient. "Tissue necrosis with hemorrhage due to erosion into a blood vessel," I wrote in the chart. But in my soul, I know it was a miracle. *Can't it be both?*

I came to understand that beyond each individual, the community was also my patient. I was practicing the specialty of community health,³ and my community was ailing. It had a sick, abusive, dysfunctional history, largely based on race and poverty. I was trying to make a sick, dysfunctional healthcare system work for the uninsured and for the poor, for people of color and for immigrants.

The patients all needed healing, but so did the community. And the longer I worked there, the more I needed healing too.

—G. R.

For the endnotes, see aft.org/hc/fall2026/rust_sb.



Trauma Counseling

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