THE PLIGHT OF HEALTH CARE IN RURAL AMERICA: HOW HOSPITAL MERGERS AND CLOSURES HARM WOMEN

ISSUE BRIEF BY **ANDREA FLYNN, RAKEEN MABUD,** AND **EMMA CHESSEN**
JUNE 2019

INTRODUCTION

Health care is one of the fastest growing and changing sectors in the US economy. Over the last decade, providers and insurers have increasingly consolidated, ultimately raising costs for patients and escalating closures of health care centers, particularly in rural areas. In more recent years, a growing body of research illustrates how these trends have affected women's access to and quality of health care, particularly before, during, and after childbirth. Ultimately, these reports shed light on a growing threat to the health and well-being of women and their families. There is, however, another dimension of the changing nature of America's health care system that remains largely under examined: the extent to which these shifts create deep challenges for the women who depend on the health care sector, especially hospitals, for jobs.

This issue brief examines how structural changes in the health care industry and health care delivery are affecting women in rural areas, both as patients and as workers. We focus on rural areas because rural hospitals, patients, and workers are acutely impacted by these shifts and are less able to weather them than are hospitals and people in other geographic areas (Weisgrau 1995). In rural communities, hospitals are often one of the only—or *the* only—"anchor institutions," which serve not only as a critical source of health care but also as a source of employment for a range of workers in the health care sector. Quality health care and employment retain and attract families to a community, and when an anchor institution disappears, it can have a cascading impact on the people who live there and on the economic health of the broader region.

Employers, policymakers, and the public at large must view and value women as both patients and workers.

CREATIVE COMMONS COPYRIGHT 2019

This brief is premised on the idea that women's health and economic security are inextricably linked; conversations about the economics of the health care system and about women's health and economic security are frequently siloed. We argue that we must not only consider how our current health care system impacts women's health in terms of access, quality, and outcomes, but we must also examine how it has reshaped labor markets in ways that directly jeopardize women's economic opportunities—and relatedly, their health. Employers, policymakers, and the public at large must view and value women not only as patients *or* workers, but as both.

Women's wages and work are disproportionately affected by changes in the health care sector, and women are also reeling from policies and politics that make it increasingly difficult for them to access comprehensive, quality, and affordable health care. The changes we are witnessing in the health care system—along with the broad political attacks on women's access to health care—are taking place alongside structural economic changes that have made it harder and harder for individuals and families in the US to achieve economic security, let alone economic mobility. The overlapping trends in the health care sector exacerbate longstanding inequities, including race and gender gaps in wealth and income and high rates of infant and maternal mortality experienced by Black and Native women.

We begin this brief by exploring some of the important shifts that have occurred across the hospital industry in rural areas over the last several decades. We then describe the effects that these shifts have had on health and labor market outcomes for women in rural areas. This issue brief concludes by shedding light on the hidden rules of gender that are shaped by corporate consolidation and suggesting future avenues for additional research.

STRUCTURAL SHIFTS IN THE HEALTH CARE SECTOR

Corporate consolidation in the health care industry has been on the rise over the last 15 years. Pink et al. (2018) find that from 2005 to 2016, there were 380 hospital mergers in rural areas—representing approximately 12 percent of all rural hospitals—and some of the hospitals included in that study merged more than once. More than half of the rural hospital mergers that took place were located in 11 states, with the greatest number of mergers taking place in Oklahoma (36), Texas (24), and Wisconsin (19).

For hospitals that cannot or do not choose to merge, closure is often the only remaining option. Ten of the hospitals that experienced a merger in the Pink et al. study ended up closing all together. The National Rural Health Association (2017) reported that between 2010-2017, nearly 80 rural hospitals closed, representing a closure rate that was six times higher in 2015 than in 2010. The Hospital Vulnerability Index (2016) identified an

additional 673 hospitals vulnerable to closure, which comprises more than one-third of all rural hospitals in the US. The study estimated that the loss of an immediate or local point of care would jeopardize more than 11 million patient encounters and result in the loss of 99,000 health care jobs; 137,000 community jobs; and $277 billion in GDP over 10 years. The economic impact would not stop there: Such rampant job loss would mean that families would have little choice but to leave the community if the vulnerable hospitals closed, ultimately depleting the tax base and eroding financial support for a broad range of public programs and services.

Waves of Consolidation

The increase in hospital consolidation in the US health care sector took place in two major waves. The first wave peaked in the late-1990s and was characterized by community hospitals merging to create small hospital systems, as well as by larger systems acquiring community hospitals to create specialty hubs. We are in the midst of the second wave of hospital consolidations, which is characterized by both horizontal and vertical consolidation. Vertical integration[1] within the industry means that hospitals are buying physicians' practices, ambulatory surgery centers, and other outpatient clinics that were previously independently owned and operated. Now, hospital systems have control of many different sites of care and are therefore caring for patients in an unprecedented fashion: away from the hub of the hospital and into smaller, decentralized locations.

This second wave of consolidation is in part a result of a range of policy choices and corporate decision-making that we have seen throughout the economy and within the industry over the past several years. First, both the economy and the hospital industry are increasingly financialized, meaning that the financial sector has an outsized presence and influence over the sector. For example, in anticipation of the Affordable Care Act (ACA) and the expanded coverage it would deliver, private equity (PE) flooded into health care and helped to spur this second wave of hospital mergers (Sorkin 2013). The introduction of these financial firms created incentives for hospital boards to rapidly cut costs in order to maximize profit for the financial interests. These rapid cost-cutting measures, alongside the shareholder pressure to raise profits, may have put pressure on these institutions to merge with larger hospital systems or other hospitals in the area.

In particular, PE firms placed big bets on the hospital industry, expecting the ACA to increase hospital admissions (and therefore profits) as more people gained health care coverage (Creswell and Abelson 2017; Sorkin 2013). These profit-maximization bets,

[1] For more on vertical integration, see Abdela, Karlsson, and Steinbaum (2019).

however, did not deliver the expected results, partly because legal challenges to the ACA allowed states to opt out of Medicaid expansion, leaving a considerable number of Americans uninsured across the country. Tellingly, none of the six states with the greatest number of hospital closures since 2010 (Texas, Tennessee, Georgia, Alabama, Mississippi, and North Carolina) have expanded Medicaid (Ellison 2018). To reduce losses, PE firms have tried a number of restructuring tactics, including mergers and acquisitions (M&A) and consolidation. Much of the discussion of M&A throughout this brief are against this broader industrial backdrop.

Rural Hospitals Face Unique Challenges

Hospitals are particularly important in rural areas where they function as anchor institutions, which serve as local hubs of economic activity to attract businesses and jobs and stimulate local economies. As Mandich and Dorfman (2014) find, "generally, health jobs are only second to the education sector in terms of total employment for rural counties. Additionally, the health sector does not provide just average jobs but high-wage, high-skill jobs." When workers receive higher wages, they have more money to spend locally, contributing to a stronger tax base and stimulating other community-based businesses. Not only do hospitals provide an important foundation for the local economy, but they also employ a range of workers who may not immediately come to mind when we think of hospital workers, such as cleaning service providers, security, and food service workers (Luthra 2018).

When a rural hospital closes, other local businesses suffer—from the restaurants that serve patients and workers at the hospital, to delivery drivers who ensure that medication and materials are present. One study found that a rural hospital closure resulted in an increase in unemployment by 1.6 percentage points and a drop in per capita income by about 4 percent (Holmes et al. 2006). It is also critical to note that in many rural communities, the broader economic trends of consolidation have already hollowed out economic opportunities, making it harder for small businesses to grow and survive and shrinking the number of employers—and therefore employment options—that exist.

Rural hospitals face a number of additional challenges that compound the pressures to cut costs. In particular, the patient population of rural areas tends to rely more heavily on government insurance and is smaller and sicker than those in urban areas.

- **More uninsured patients and higher reliance on Medicare or Medicaid:** In most states, rural counties have a higher proportion of individuals insured by Medicaid than urban areas. In California, for example, Medicaid coverage rates are 16 percent higher

in rural areas than urban ones (Foutz et al. 2017). Medicaid coverage reimbursement rates are usually much lower than those of private insurers, and as a result, critical services are often much more expensive to provide in rural areas than urban ones. Rural areas rely heavily on Medicaid; the program covers over 50 percent of rural births (Luthra 2018). In states that did not expand Medicaid, uninsured rates and uncompensated care costs remain much higher than in those that did expand Medicaid.

- **Smaller patient populations**: The population in rural communities has been shrinking as a result of declining birth rates, rising mortality rates among working-age adults, an aging population (Cromartie 2017), and the disappearance of employment opportunities in sectors like manufacturing, mining, and agriculture. Additionally, rapidly changing technologies have shifted care away from the traditional hospital setting, resulting in more decentralized health care and reducing the dependency on a single hospital.
- **Sicker patient populations**: Patients in rural areas are more likely to have chronic illnesses, multiple health concerns, and socioeconomic disadvantages that are linked with negative health outcomes (Lapointe 2017; National Advisory Committee on Rural Health and Human Services 2008). Populations in rural areas have lower median household incomes, higher child poverty rates, fewer adults with postsecondary educations, and more uninsured residents under age 65 (Rural Health Snapshot 2017). According to the Centers for Disease Control and Prevention (CDC), rural communities experience higher rates of the five leading causes of death in the US: heart disease, cancer, unintentional injury (including vehicle accidents and opioid overdoses), chronic lower respiratory disease, and stroke (Warsaw 2017).

The financial pressures to cut costs make rural hospitals vulnerable, and many are forced to shrink their workforces or restructure to survive. For a rural hospital, closure or a merger with a larger hospital (or hospital system) are often alternative end points to financial distress and may be the only way for a hospital to acquire new technologies needed to provide high-quality care. A merger or acquisition may allow the hospital to continue to serve the community and buoy the local economy, although it is often in a significantly reduced capacity.

HOW HOSPITAL CLOSURES AND CONSOLIDATION HURT WOMEN IN RURAL COMMUNITIES

The trends we describe above have a wide range of implications for households and communities across the country. Women in rural areas face a range of socioeconomic

challenges that hurt both their health and their employment opportunities—factors that are deeply related. In this section, we examine how hospital closures and mergers affect access to care, hinder economic opportunities, and jeopardize overall patient well-being.

Women's Work and Wages

In rural America, hospitals often serve as pillars of local labor markets; this is especially true in areas that have experienced the precipitous decline of other industries (e.g., manufacturing) in recent decades (Perez and Stovall 2011). In these communities, health care sector employment is critical for women, offering steady jobs at a range of professional levels, from cleaners to nurses and specialists. Hospital closures and hospital mergers or acquisitions can have more dire outcomes for women workers in rural areas than for those in other areas. In the next two subsections, we explore each of these scenarios, respectively.[2]

Hospital Closures

Rural health care is in crisis: The closures of hospitals in rural areas exacerbate existing health disparities. Since 2010, 95 acute care hospitals have closed in rural areas, and over 30 percent happened since 2016 (UNC n.d.). "In other words, many of the hospitals most at risk of closure are located in communities that can least afford to lose access to care," as argued in the Hospital Strength INDEX study (iVantage Health Analytics 2016).

> ***"In other words, many of the hospitals most at risk of closure are located in communities that can least afford to lose access to care."***

The closure of a rural hospital disproportionately affects women, who are more likely to hold jobs in the health sector, especially those who occupy positions that require fewer educational qualifications and pay lower salaries. As Appelbaum and Batt (2017) write, health care jobs comprise six major occupational groups: health care professionals, social service workers, medical technicians, health aides and assistants, food service workers, and cleaning service workers. Jobs in these occupational groups are dominated by women, many of who are immigrant women and women of color. Nationally, women comprise the vast majority of nurses, care workers, and foodservice workers (91.7 percent, 95.6 percent, and 56.0 percent, respectively) (Mabud and Forden 2018; BLS 2017).[3]

---

[2] For the sake of comparison, we assume that if a hospital has been acquired, it does not close. This of course does not always hold.

[3] See BLS Occupational employment statistics "employment by state" and "location quotient" maps for "Healthcare Practitioners and Technical" and "Healthcare Support" at https://www.bls.gov/oes/2017/may/map_changer.htm.

Even women who find jobs at other health care facilities may experience a range of challenges that jeopardize their well-being. Just as patients may face increased travel times to health service centers after hospital closures in rural areas, hospital workers can face increased time and costs in getting to and from work (Frakt 2018; Hung et al. 2016). Combined with trends like just-in-time scheduling—a scheduling practice in which workers are called into work on short notice or might see their shifts cancelled at the last minute—these changes can cause significant hardship for women workers. Hospital employees, such as nurses, are frequently forced to operate on these types of schedules—a fact of life for too many that can hurt emotional and mental well-being and can create significant financial instability (Ansel 2015). The combination of commute time and unpredictable scheduling is particularly onerous on the working poor and those living outside of major metropolitan areas (Roberto 2008). These effects are magnified for women workers, who are often the primary caregivers to children or the elderly and must juggle the financial and emotional burden of long commutes, last-minute schedule shifts, and finding care for their dependents.

Hospital Consolidation

Hospital consolidation has different, although related, effects on health care workers. There are two primary ways in which hospital consolidation affects hospital workers in the rural labor market. First, hospital consolidation may result in employers gaining outsized power to bargain down wages or working conditions. Second, the drive to lower costs (often cited as a factor in the consolidation itself) may result in a greater reliance on outsourced jobs. An extensive body of research also illustrates how corporate consolidation increases employer power and consequently affects labor market outcomes, such as wages and working conditions. There is a shortage of research on how these trends play out in the health care sector, and the scant research that does exist provides mixed evidence on the labor market effects of hospital consolidation.

There is also a lack of research that details how women specifically are impacted by these trends of consolidation. However, given the high proportion health care sector jobs occupied by women and the existing race and gender inequities they already experience in the labor market and in our society and economy more broadly, it is important to consider how the broader trends in consolidation might impact women workers.

Research applied to a variety of industries shows that when the demand for a certain type of worker decreases (e.g., full-time nurses or physicians' assistants), the employer that remains has more power to bargain down the wages or working conditions because they exploit the fact that there are few other employment opportunities nearby (Council of Economic Advisors 2016).[4] These effects are magnified in rural areas, where hospitals often

[1] Economists refer to this trend as labor market monopsony.

serve as local labor market hubs and outside employment options are more limited (Azar, Marinescu, and Steinbaum 2017).

Outsized employer power as a result of hospital consolidation, combined with the drive to lower costs, may also affect the work environment for women workers in rural health care markets. As can be seen in other sectors, such as the hotel and grocery industries, increased financial pressure and the pursuit to cut costs and raise profits—both driven by shareholders and executives—lead to greater "fissuring" or subcontracting of labor markets. This means that hospital systems outsource jobs that were previously kept in house (Weil 2014). Full-time nurses have provided anecdotal evidence that they see their positions being taken over by contracted nursing staff, a trend that is proliferating through the labor market more broadly. Contract workers have less power than full-time workers to demand higher wages or benefits, which can ultimately weaken the ability of all employees to demand better terms of employment (Alexander 2018).

Recent research suggests that increased monopsony power created by hospital mergers may have a negative impact on wages. In their 2019 study on employer concentration and hospital wages, Prager and Schmitt find that when workers' skills are industry specific, wage growth declines as concentration increases. Notably, this post-merger decline in wages is mitigated when workers are unionized. Prager and Schmitt's finding are not specific to rural areas. However, given that employer concentration tends to be higher in rural areas, we might expect that their findings would be exacerbated in more rural labor markets (Prager and Schmitt 2019).

Similarly, Staiger, Spetz, and Phibbs (2010) note that there is real reason to believe that registered nurses are subject to monopsony power. Particularly in rural areas where there is only one hospital in a community, that hospital has immense market power as an employer. Leveraging a natural experiment where nursing wages at Veterans Affairs hospitals were changed by legislation, the paper finds evidence for monopsony power in nursing. Others including Depasquale (2014) find no evidence of monopsony power. However, the field of research on monopsony, and particularly how it impacts specific communities, is emergent. Future research should focus on the multiple dimensions of growing monopsony power and how it intersects with other economic trends that have been harmful to women workers.

The current research in this space is largely limited to nursing wages, and much more empirical work needs to be done to examine the ways that hospitals use their market power to affect not only other kinds of workers in hospitals but also the *quality* of jobs. Greater employer leverage over workers often manifests in ways outside of wages—in fewer benefits, less predictable schedules, and fewer breaks. Research on the labor market effects of consolidation in the Californian hospital industry corroborates this. Currie, Farsi, and

MacLeod (2002) find that the quality of nursing jobs declines after a merger or acquisition. Ultimately, nurses are expected to support a heavier patient load after a hospital merger. Other evidence shows that following consolidation, nurses are more likely to be rotated through different parts of the hospital rather than given the usual breaks (Sochalski and Aiken 1999). This research shows that mergers reduce job quality by overburdening health care providers, which impacts the health of those workers and also has direct implications on patient outcomes.

Women's Health and Well-Being

In many communities, the trends we have described above translate into a lack of access to critical services and an increased risk of negative health outcomes. In the case of both closure and consolidation, critical services can disappear or be moved far away from a community, resulting in a significant mismatch between what patients need and what providers offer.

Hospital Closures

One of the most significant consequences of hospital closures is the loss of obstetric and maternity care in communities. By 2014, more than half of all rural US counties had no hospital obstetric services, according to a recent study at the University of Minnesota School of Public Health. They found that from 2004 to 2014, 9 percent of rural counties lost the hospital obstetric care they once had (Hung et al. 2017). Individuals in rural areas are more likely than those in other areas to rely on nearby hospitals as their primary source of health care, especially obstetric care. The loss of pre- and postnatal care, and also emergency maternity care that results from a hospital closure, can put women and their pregnancies at significant risk (Joszt 2018).

When a rural hospital closes, the distance between the closest hospital and the patient population can increase significantly. Hsia and Shen (2011) find that closures of hospital trauma centers disproportionately impact marginalized communities and increase travel times to trauma centers by 30 minutes or more. Increased travel times can have negative impacts on patient outcomes and are even correlated with higher mortality rates for patients with traumatic or severe conditions (Chou, Deily, and Li 2014; Hsia and Shen 2011). This is particularly harmful when it comes to pre- and postnatal care if expecting mothers have to drive significantly further distances for routine care or an emergency.

Fewer than half of women in rural areas live within a 30-minute drive to a hospital with maternity services and only 6 percent of OB-GYNs in the US practice in rural areas, according to the American College of Obstetricians and Gynecologists (ACOG) (2014).

As a result of this distance, some pregnant women delay seeking care, skip prenatal care appointments, and schedule caesarian sections to avoid going into labor and not being able to get to a hospital quickly. Adding to this problem is the fact that when hospitals close in rural areas, ambulatory services also tend to decline, ultimately making it increasingly difficult for women to get to other sites of care quickly in emergency situations. It's not hard to imagine how this situation would quickly spiral into a crisis for women who do not have reliable transportation or a support network that can get them to the closest hospital. The continued loss of obstetric care threatens to exacerbate these outcomes.

Intersecting Trends: Maternal Mortality and a Changing Health Sector

The loss of obstetric and maternity care must be considered in the context of a growing maternal mortality and morbidity crisis in the US. These deaths are preventable, but the disappearance of hospitals and health care centers that are equipped to deliver maternal and fetal medicine will only exacerbate the problem.

America is one of the most developed countries in the world that has experienced an increase in its maternal mortality rate—with rates in some Black communities as high as those in developing nations—while the vast majority of countries have seen significant declines. A *Scientific American* study (2017) found that the maternal mortality rate in most rural areas was 29.4 women per 100,000 live births, compared to 18.2 women per 100,000 in large central metropolitan areas. (This can be contrasted with rates in the United Kingdom and Sweden, which are 8.9 and 4.6, respectively).

As Maron (2017) writes, "Exactly why this happens is unclear. Underlying health conditions such as hypertension or diabetes could be factors, alongside poor prenatal care and geographic access. But the numbers are troubling, and the same trend holds true for infant mortality rates, according to the analysis of CDC figures." Data from 2000 to 2012 illustrated that when compared with women and infants in urban areas, those in the most rural areas had higher rates of delayed prenatal care initiation, pregnancy-related hospitalizations, low birth weight, preterm births, and infant mortality (Kozhimannil et al. 2018; ACOG 2014).

Hospital Consolidation

There are a number of channels through which hospital consolidation affects women's health outcomes. First, key services for women, such as obstetrics and gynecology care, are often the first services to be cut. Second, women may be less able to access key services because mergers result in services being moved to less accessible locations. Third, new health care providers, unfamiliar with the health and cultural context of the rural area,

may result in adverse health outcomes. Finally, decision-making about the hospital system ceases to be at the local level or take local concerns into consideration.

Labor and delivery units are expensive to maintain and are often poorly reimbursed (Pearson 2017). In rural areas, with higher rates of Medicaid patients, maternity care is less profitable than in urban areas and is therefore often the first service to be cut when a hospital is financially struggling. Medicaid pays for slightly less than half of all births in the US, but it also only reimburses about half of the amount that private insurance does (Andrews 2016). A large health care system that absorbs a smaller community hospital might decide to close one labor and delivery unit because they have one at another facility that they deem to be geographically close (enough). They might also house labor and delivery services at a central provider to cut costs and prevent redundancy in the hospital system, regardless of how accessible it is in practice for the local community.

Proximity is much more than mileage—we must consider the full range of factors that impact a community's ability to traverse greater geographic distances in order to access care. For example, do the majority of individuals have access to private transportation and/or is there public transportation available to the new facility? Are there frequent weather-related events that might make it difficult for individuals to travel to the new center? Are people employed in jobs that will allow them to miss work for appointments? Do people have access to affordable childcare?

Accounts of rural women being unable to access routine maternal care in the wake of mergers and closures have been increasingly documented across the country over the last several years. In July 2018, the *Casper Star Tribune* described the difficulty in accessing maternity care in rural Wyoming, where women have to drive for hours to get to the nearest OB-GYN and often rely on family practice physicians for prenatal care (King 2018). Days later, the *New York Times* covered access to maternity care in Missouri, where a woman went into labor and was 100 miles away from her doctor and the hospital she was supposed to deliver (Healy 2018). When Mission Health in North Carolina was recently sold to a Tennessee-based hospital system, it shut down labor-and-delivery services at half of its hospitals, and expecting mothers in the Blue Ridge Mountain Range had to drive at least 20 miles on winding mountain roads to the nearest labor-and-delivery center (Pearson and Taylor 2017).

Consolidation can also bring a new set of health care providers to a rural area, which can be difficult for patients for a variety of reasons. After a merger, patients may no longer be familiar with their new providers, and the new providers may not be familiar with or trained to address the specific needs of those patients. For example, physicians may be moved to work with a primarily non-English speaking community or one with more young or elderly

patients. If providers do not have extensive experience working with these populations, they may have a difficult time building strong and trusting relationships with their patients, increasing the risk of misdiagnosis, poor or culturally incompetent treatment, and even harm (Haas et al. 2018). These concerns are particularly salient in the sexual and reproductive health field, where providers must be equipped to deal with a range of deeply personal health issues.

In addition, large hospital systems with more funding resources often make changes to infrastructure, such as equipment, protocols, and information systems, without adequate training for the physicians and staff at the hospitals. Specialists are moved around a system to unfamiliar facilities and settings that they are not comfortable practicing in. Though proponents of consolidation may argue that physician networks will become broader and more coordinated, staff's unfamiliarity with new patients and new settings puts all patients at risk (Haas et al. 2018; Bowman 2013).

Finally, as rural hospitals undergo M&As or close, decision-making about what kinds of services are offered, how much those services will cost, and where they will be offered often move further and further away from the local level. The Kaiser Family Foundation has found that corporate decision-making, driven by an executive eye toward cutting costs and maximizing profits, drives choices to close many rural hospitals—not an assessment of local needs or planning. Their research examining rural hospital closures finds that rather than looking at the needs of a local community, many rural hospitals were closed without a "local process of consultation or public input" (Wishner 2016).

Corporate decision-making, driven by an executive eye toward cutting costs and maximizing profits, drives choices to close many rural hospitals—not an assessment of local needs or planning.

Consolidated hospital systems also result in little to no decision-making at the local level. Ascension, one of the largest non-profit hospital systems, for example, is based in St. Louis, Missouri, and its facilities extend as far as Washington state, Florida, and Connecticut. Administrators of large, consolidated hospital systems like Ascension make decisions far away from the communities in which those decisions are implemented. This amounts to administrators taking a birds-eye view of a health care system and cutting services in hospitals where it makes the most financial sense, despite what the greatest needs are within a community.

CONCLUSION

The trends in the hospital industry mirror broader trends in our society. Workers today have less power, patients have less access to quality care, and corporations are gaining more and more consolidated power. As the rules of our economy allow corporations to value profit over people, the unchecked trends in the health care industry underscore the extreme cost that these shifting power dynamics have for rural Americans.

The increased cost pressures put on hospitals in rural areas by those at the top, including shareholders and CEOs, are resulting in closures and consolidation that are reaching a greater rate than we have previously seen. Because of women's reliance on hospitals—and health care systems more broadly—for both care and jobs, these trends significantly threaten the well-being of rural women. Though the research on how closures and consolidation in the hospital industry affect women's health is robust and well documented, much more research is necessary to understand how women are faring—or being held back—in the labor market as a result of the changing hospital industry.

The economic trends outlined in this brief take place against two important backdrops: one of a societal disregard for women's health and rights, and another of increased consolidation across the entire economy. Since 2010, states have shuttered family planning and abortion clinics, and both state and federal policies have rapidly eroded the reproductive health safety net that has been a critical source of care to millions of women for decades. Given the current political climate, it is likely that this critical public health infrastructure will be eroded even further. The disappearance of rural hospitals is compounded by the closure (or threatening closure) of local clinics, both of which carry significant consequences for underserved communities, particularly women of color, young women, and immigrant women—both rural and urban.

Additionally, growing consolidation has eroded economic opportunities in rural communities, shrinking the number of employers—and therefore employment options—that exist, and making it especially difficult for small businesses to survive.

Existing policy tools can be used to address consolidation in the health care sector. When assessing health care consolidation, potential consequences are only measured by whether they affect health care consumers (i.e., the effects on patients). In particular, the Federal Trade Commission (FTC) could go beyond the "consumer welfare standard" (CWS), the primary standard that is currently used to determine whether mergers in any sector are harmful or not and implement a new, more comprehensive standard (Steinbaum and Stucke 2018). The CWS "means exactly what it says: that only outcomes facing consumers 'count' when it comes to assessing anti-competitive harm, and in practice, those outcomes are

restricted to short-term price effects" (Steinbaum 2017).

Naidu, Posner, and Weyl (2018) find that the Department of Justice and the FTC "have never blocked a merger because of its effect on labor markets[—]or, even, as far as we know, given the labor market effects of a potential merger more than cursory attention." Given the significant potential consequences that the merger, acquisition, or closure of a hospital can have on local labor markets and the economic well-being of a rural community, we suggest that the FTC take a broader view of what constitutes harm.

Women's health and economic security are inextricably linked. Efforts to dismantle one is an attack on the other—after all, women are not *just* patients or *just* workers but both. The individuals whose wages and work are disproportionately affected by changes in the hospital industry are also reeling from a health care system that has made it increasingly difficult for women to access comprehensive, quality, and affordable care. The changes in labor markets and working conditions we describe in this brief not only impact women's economic opportunities and security, but they also directly and indirectly impact women's health and that of their families too.

Given the significant potential consequences that the merger, acquisition, or closure of a hospital can have on local labor markets and the economic well-being of a rural community, we suggest that the FTC take a broader view of what constitutes harm.

Ultimately, the circumstances facing women in rural America illustrate the crucial need to rewrite the rules of our economy. We must better regulate corporations whose unchecked power is wreaking havoc on rural communities and expand our investments in public programs and policies with the goal of achieving health and economic equity.

REFERENCES

Abdela, Adil, Kristina Karlsson, and Marshall Steinbaum. 2019. "Vertical Integration and the Market Power Crisis." Roosevelt Institute. http://rooseveltinstitute.org/vertical-integration-and-the-market-power-crisis/.

Alexander, Brian. 2018. "America's Rural Hospitals Are Dangerously Fragile." *The Atlantic*, January 9, 2018. https://www.theatlantic.com/business/archive/2018/01/rural-hospitals/549050/.

Andrews, Michelle. 2016. "More Rural Hospitals Are Closing Their Maternity Units." *NPR*, February 24, 2016. https://www.npr.org/sections/health-shots/2016/02/24/467848568/more-rural-hospitals-are-closing-their-maternity-units.

Ansel, Bridget. 2015. "The Pitfalls of Just-In-Time Scheduling." Washington Center for Equitable Growth. https://equitablegrowth.org/pitfalls-just-time-scheduling/.

Antonisse, Larisa, Rachel Garfield, Robin Rudowitz, and Samantha Artiga. 2018. "The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review." Henry J. Kaiser Family Foundation. https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-march-2018/.

The American College of Obstetricians and Gynecologists. 2014. "Health Disparities in Rural Women." Committee on Health Care for Underserved Women. Committee Opinion, No. 586. https://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co586.pdf?dmc=1&ts=20160402T0931414521.

Appelbaum, Eileen, and Rosemary Batt. 2017. "Organizational Restructuring in US Healthcare Systems: Implications for Jobs, Wages, and Inequality." September 2017. Center for Economic and Policy Research. https://healthcareworkers.us/wp-content/uploads/2018/08/organizational-restructuring-healthcare-2017-09.pdf.

Ascension. 2018. "Facts and Stats." Accessed December 3, 2017. https://ascension.org/About/Facts-and-Stats. USA: McGraw Hill Books.

Jose Azar, Ioana Marinescu, and Marshall Steinbaum. 2017. "Labor Market Concentration." National Bureau of Economic Research. Working Paper 24147. https://doi.org/10.3386/w24147.

Becker's Healthcare. 2014. "AHA: Hospital Medicare, Medicaid Payments Cut by $113 Billion Since 2010." Becker's Hospital CFO Report. https://www.beckershospitalreview.com/finance/aha-hospital-medicare-medicaid-payments-cut-by-113b-since-2010.html.

Bodenheimer, Thomas, and Kevin Grumbach. 2012. *Understanding Health Policy: A Clinical Approach*. Sixth Edition.

Bowman, Sue. 2013. "Impact of Electronic Health Record Systems on Information Integrity: Quality and Safety Implications." *Perspectives in Health Information Management* 10 (Fall). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3797550/.

Bureau of Labor Statistics. 2017. "May 2017 OES Maps." BLS. Occupational Employment Statistics. Accessed December 3, 2018. https://www.bls.gov/oes/2017/may/map_changer.htm.

Centers for Medicare and Medicaid Services. 2017. "MLN Booklet: Hospital Values-Based Purchasing." CMS. Medicare Learning Network. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Hospital_VBPurchasing_Fact_Sheet_ICN907664.pdf.

Chou, Shinyi, Mary E. Deily, and Suhui Li. 2014. "Travel Distance and Health Outcomes for Scheduled Surgery." *Medical Care* 52, no. 3 (March): 250-57. https://doi.org/10.1097/MLR.0000000000000082.

Council of Economic Advisors. 2016. "Labor Market Monopsony: Trends, Consequences, and Policy Responses." https://obamawhitehouse.archives.gov/sites/default/files/page/files/20161025_monopsony_labor_mrkt_cea.pdf.

Creswell, Julie, and Reed Abelson. 2017. “For One Hedge Fund, a Bet on the Affordable Care Act Sours.” *New York Times*, September 11, 2018. https://www.nytimes.com/2017/09/11/business/affordable-care-act-hospitals.html.

Cromartie, John. 2017. Rural Areas Show Overall Population Decline and Shifting Regional Patterns of Population Change.” United States Department of Agriculture Economic Research Service. https://www.ers.usda.gov/amber-waves/2017/september/rural-areas-show-overall-population-decline-and-shifting-regional-patterns-of-population-change/.

Cuda, Amanda. 2018. “Healthcare Mergers and Acquisitions Hit a National High.” *CT Post*, March 31, 2018. https://www.ctpost.com/local/article/Healthcare-mergers-and-acquisitions-hit-a-12794610.php.

Curie, Janet, Mehdi Farsi, and Bentley McLeod. 2002. “Cut to the Bone? Hospital Takeovers and Nurse Employment Contracts.” NBER. https://doi.org/10.3386/w9428

DePasquale, Christina. 2014. “Hospital Consolidation and the Nurse Labor Market.” Emory University, Department of Economics. http://economics.emory.edu/home/documents/workingpapers/depasquale_14_13_paper.pdf.

Ellison, Ayla. 2018. “State-by-State Breakdown of 85 Rural Hospital Closures.” *Becker’s Hospital Review*. (July). https://www.beckershospitalreview.com/finance/state-by-state-breakdown-of-85-rural-hospital-closures.html.

Fleming Steven T., Harold A. Williamson, Lanis L. Hicks, and Isabel Rife. 1995. “Rural Hospital Closures and Access to Services.” *Hospital and Health Services Administration*, 40, no. 2:247-262. https://www.ncbi.nlm.nih.gov/pubmed/10143034.

Frakt, Austin. 2018. “A Sense of Alarm as Rural Hospitals Keep Closing.” *The Upshot*, October 29, 2018. https://www.nytimes.com/2018/10/29/upshot/a-sense-of-alarm-as-rural-hospitals-keep-closing.html.

Foutz, Julia, Samantha Artiga, and Rachel Garfield. 2017. “The Role of Medicaid in Rural America.” The Henry J. Kaiser Family Foundation. http://files.kff.org/attachment/Issue-Brief-The-Role-of-Medicaid-in-Rural-America.

Gaynor, Martin. “Examining the Impact of Health Care Consolidation.” Statement before the Committee on Energy and Commerce Oversight and Investigations Subcommittee. 115th Cong., 1st sess. 2018. https://docs.house.gov/meetings/IF/IF02/20180214/106855/HHRG-115-IF02-Wstate-GaynorM-20180214.pdf.

Gaynor, Martin, Farzad Mostashari, and Paul B. Ginsburg. 2017. “Making Health Care Markets Work: Competition Policy for Health Care.” Brookings Institute. https://www.brookings.edu/wp-content/uploads/2017/04/gaynor-et-al-final-report-v11.pdf.

Gaynor, Martin, Rodrigo Moreno-Serra, and Carol Propper. 2010. “Death by Market Power: Reform, Competition and Patient Outcomes in the National Health Service.” NBER Working Paper. https://doi.org/10.3386/w16164.

Haas, Susan, Atul Gawande, and Mark Reynolds. 2018. “The Risks to Patient Safety from Health System Expansions.” JAMA 319, no. 17 (May 2018): 1765-6. https://doi.org/10.1001/jama.2018.2074.

Healy, Jack. 2018. “It’s 4 A.M. The Baby’s Coming. But the Hospital Is 100 Miles Away.” *New York Times*, July 17, 2018. https://www.nytimes.com/2018/07/17/us/hospital-closing-missouri-pregnant.html.

Holmes, George M, Rebecca T. Slifkin, Randy K. Randolp, and Stephanie Poley. 2006. “The Effect of Rural Hospital Closures on Community Economic Health.” ˆHealth Services Resarch, 21(2):467-486 (April). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1702512/

Hsia, Renee Y., and Yu-Chu Shen. 2011. “Rising Closures of Hospital Trauma Centers Disproportionately Burden Vulnerable Populations.” *Health Affairs* 30, no. 10 (October): 1912-20. https://doi.org/10.1377/hlthaff.2011.0510.

iVantage Health Analytics. 2016. “Rural Relevance: Vulnerability to Value.” Hospital Strength Index Study. https://www.chartis.com/resources/files/INDEX_2016_Rural_Relevance_Study_FINAL_Formatted_02_08_16.pdf.

Hung, Peiyin, Carrie E. Henning-Smith, Michelle M. Casey, and Katy B. Kozhimannil. 2017. “Access to Obstetric Services in Rural Counties Still Declining, with 9 Percent Losing Services, 2004-14.” Health Affairs 36, no. 9 (September). https://doi.org/10.1377/hlthaff.2017.0338.

Hung, Peiyin, Katy B. Kozhimannil, Michelle M. Casey, and Ira S. Moscovice. 2016. “Why Are Obstetric Units in Rural Hospitals Closing Their Doors?” *Health Services Research* 51, no. 4 (August): 1546-60. https://doi.org/10.1111/1475-6773.12441.

Joszt, Laura. 2018. “Loss of Obstetric Services in Rural Counties Associated with Childbirth Risks.” AJMC. https://www.ajmc.com/focus-of-the-week/loss-of-obstetric-services-in-rural-counties-associated-with-childbirth-risks.

King, Katie. 2018. “In Rural Wyoming, Women Must Often Travel Great Distances for Prenatal Care.” *Casper Star Tribune*, July 15, 2017. https://trib.com/news/state-and-regional/in-rural-wyoming-women-must-often-travel-great-distances-for/article_f9f395d1-52df-516d-b75a-ad66cc1c4996.html.

Kozhimannil, Katy B., Peiyin Hung, Carrie Henning-Smith, Michelle M. Casey, and Shailendra Prasad. “Association Between Loss of Hospital-Based Obstetric Services and Birth Outcomes in Rural Counties in the United States.” *JAMA* 319, no. 12 (March): 1193. https://doi.org/10.1001/jama.2018.1646.

LaPointe, Jacqueline. 2017. “Top 4 Rural Hospital Challenges with Revenue Cycle Management.” Revcycle Intelligence. (August) https://revcycleintelligence.com/news/top-4-rural-hospital-challenges-with-revenue-cycle-management.

Luthra, Shefali. 2018. “Medicaid Is Rural America’s Financial Midwife.” Kaiser Health News. March 12, 2018. https://khn.org/news/medicaid-is-rural-americas-financial-midwife/.

Mabud, Rakeen and Jess Forden. 2018. “Left Behind: Snapshots from the 21st Century Labor Market.” Roosevelt Institute. http://rooseveltinstitute.org/wp-content/uploads/2018/09/LeftBehind_FINAL.pdf.

Mandich, Anne M., and Jeffery H. Dorfman. 2014. “The Impact of Hospitals on Local Labor Markets: Going Beyond IMPLAN.” Agricultural and Applied Economics Association. 2014 Annual Meeting. No 169791. http://ageconsearch.umn.edu/bitstream/169791/2/Hospital%20Employment%20Final.pdf.

Maron, Dina Fine. 2017. “Maternal Health Care Is Disappearing in Rural America.” *Scientific American*. February 15, 2017. https://www.scientificamerican.com/article/maternal-health-care-is-disappearing-in-rural-america/.

Naidu, Suresh, Eric A. Posner, and E. Glen Weyl. 2018. “Antitrust Remedies for Labor Market Power.” Columbia Law and Economics Working Paper. https://dx.doi.org/10.2139/ssrn.3129221.

National Rural Health Association. 2017. “NRHA endorses reintroduction of Save Rural Hospitals Act to new Congress.” Government Affairs Office. https://www.ruralhealthweb.org/NRHA/media/Emerge_NRHA/Press%20releases/NRHA-Release-2017-Save-Rural-Hospitals-Act.pdf.

North Carolina Rural Health Research Program. 2017. “Rural Health Snapshot.” (May) http://www.shepscenter.unc.edu/download/14853/

Pearson, Catherine, and Frank Taylor. 2017. “Mountain Maternity Wards Closing, WNC Women’s Lives on the Line.” *Carolina Public Press*, September 25, 2017. https://carolinapublicpress.org/27485/mountain-maternity-wards-closing/.

Perez, Jessica, and Tess Stovall. 2011. “Priming Today’s Workers for Tomorrow’s Jobs.” Third Way. http://thirdway.imgix.net/pdfs/priming-todays-workers-for-tomorrows-jobs.pdf.

Pink, George H., Kristie Thompson, H. Ann Howard, and Mark Holmes. 2018. “Geographic Variation in the 2016 Profitability of Urban and Rural Hospitals.” NC Rural Health Research Program. University of North Carolina Chapel Hill. http://www.shepscenter.unc.edu/programs-projects/rural-health/projects/north-carolina-rural-health-research-and-policy-analysis-center/publications/.

Pink, George H., Dunc Williams Jr., Sharita R. Thomas, and Hilda Holmes. 2018. “Rural

Hospital Mergers from 2005 through 2016.” North Carolina Rural Health Research and Policy Analysis Center. https://www.ruralhealthresearch.org/alerts/249

Prager, Elena and Matt Schmitt. 2019. “Employer Consolidation and Wages: Evidence from Hospitals.” https://www.google.com/url?q=https%3A%2F%2Ffaculty.kellogg.northwestern.edu%2Fmodels%2Ffaculty%2Fm_download_document.php%3Fid%3D471&sa=D&sntz=1&usg=AFQjCNFCUx2rR3DODXUms8Bfs0ps7KkqEQ.

Roberto, Elizabeth. “Commuting to Opportunity: The Working Poor and Commuting in the United States.” Metropolitan Policy Program. Brookings. https://inequality.stanford.edu/sites/default/files/media/_media/pdf/key_issues/transportation_policy.pdf.

Rogers, Simon. 2010. “Maternal Mortality: How Many Women Die in Childbirth in Your Country?” *The Guardian*, April 13, 2010. http://www.theguardian.com/news/datablog/2010/apr/12/maternal-mortality-rates-millennium-development-goals.

Ross, Casey. 2018. “Paying More and Getting Less: As Hospital Chains Grow, Local Services Shrink.” *StatNews*, January 24, 2018. https://www.statnews.com/2018/01/24/hospital-chains-services-consolidation/.

Ruckelshaus, Catherine, Rebecca Smith, Sarah Leberstein, and Eunice Cho. 2014. “Who’s the Boss: Restoring Accountability for Labor Standards in Outsourced Work.” National Employment Law Project. (May) https://www.nelp.org/wp-content/uploads/2015/02/Whos-the-Boss-Restoring-Accountability-Labor-Standards-Outsourced-Work-Report.pdf

Sochalski, Julie, and Linda H. Aiken. 1999. “Accounting for Variation in Hospital Outcomes: A Cross National Study.” Health Affairs 18, no. 3 (May/June): 256-59. https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.18.3.256.

Sorkin, Andrew Ross. 2013. “Tenet to Acquire Vanguard Health Systems for $1.8 Billion.” *New York Times*, June 24, 2013. https://dealbook.nytimes.com/2013/06/24/tenet-to-acquire-vanguard-health-systems-for-1-8-billion/?mcubz=1.

Staiger, Douglass O., Joanne Spetz, and Ciaran S. Phibbs. 2010. “Is There Monopsony in the Labor Market? Evidence from a Natural Experiment.” *Journal of Labor Economics* 28, no. 2. https://www.dartmouth.edu/~dstaiger/Papers/2010/staiger%20spetz%20phibbs%20monopsony%20jole%202010.pdf.

Steinbaum, Marshall. 2017. “The Consumer Welfare Standard is an Outdated Holdover from a Discredited Economic Theory.” The Roosevelt Institute, December 11, 2017. http://rooseveltinstitute.org/consumer-welfare-standard-outdated-holdover-discredited-economic-theory/.

Steinbaum, Marshall, and Maurice E. Stucke. 2018. “The Effective Competition Standard: A New Standard for Antitrust.” Roosevelt Institute. http://rooseveltinstitute.org/effective-competition-standard/.

The National Advisory Committee on Rural Health and Human Services (NACRHHS). 2008. “The 2008 Report to the Secretary: Rural Health and Human Services Issues.” https://www.hrsa.gov/advisorycommittees/rural/2008secreport.pdf.

Thompson, Derek. 2018. “Health Care Just Became the U.S.’s Largest Employer.” *The Atlantic*, January 9, 2018. https://www.theatlantic.com/business/archive/2018/01/health-care-america-jobs/550079/?utm_source=atltw.

United States Government Accountability Office. 2018. “Rural Hospital Closures: Number and Characteristics of Affected Hospitals and Contributing Factors.” https://www.gao.gov/assets/700/694125.pdf.

University of North Carolina Chapel Hill. n.d. “90 Rural Hospital Closures: January 2010-Present.” The Cecily G. Sheps Center for Health Services Research. Accessed December 3, 2018. http://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/.

Virginia Hospital and Healthcare Association (VHHA). 2014. “No Margin for Error: Virginia’s Rural Hospitals at a Crossroads.” October 2014. http://www.vhha.com/research/wp-content/uploads/sites/18/2014/10/No-Margin-for-Error-v.-3.pdf.

Vogt, Wiliam B., and Robert Town. 2006. “How Has Hospital Consolidation Affected the Price and Quality of Hospital Care.” Robert Wood Johnson Foundation. The Synthesis Project. https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2006/rwjf12056/subassets/rwjf12056_1.

Warsaw, Robin. 2017. “Health Disparities Affect Millions in Rural U.S. Communities.” Association of American Medical Colleges News. (October) https://news.aamc.org/patient-care/article/health-disparities-affect-millions-rural-us-commun/.

Weil, David. 2014. *The Fissured Workplace: Why Work Became So Bad for So Many and What Can Be Done to Improve It*. Cambridge: Harvard University Press.

Weisgrau, Sheldon. 1995. “Issues in Rural Health: Access, Hospitals, and Reform.” Healthcare Finance Review 17, no. 1 (Fall): 1-14. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4193574/.

Williams Jr., Dunc, Sharita R. Thomas, Hilda A. Howard, and George H. Pink. 2018. “Rural Hospital Mergers from 2005 to 2016.” NC Rural Health Research Program. University of North Carolina Chapel Hill. http://www.shepscenter.unc.edu/programs-projects/rural-health/projects/north-carolina-rural-health-research-and-policy-analysis-center/publications/.

Wishner, Jane, Patricia Solleveld, Robin Rudowitz, Julia Paradise, and Larisa Antonisse. 2016. “A Look at Rural Hospital Closures and Implications for Access to Care: Three Case Studies.” Kaiser Family Foundation. https://www.kff.org/report-section/a-look-at-rural-hospital-closures-and-implications-for-access-to-care-three-case-studies-issue-brief/.

Xu, Xiao, Aileen Gariepy, Lisbet S. Lundsberg, Sangini S. Sheth, Christian M. Pettker, Harlan M. Krumholz, and Jessica L. Illuzzi. 2016. “Wide Variation Found in Hospital Facility Costs for Maternity Stays Involving Low-Risk Childbirth.” *Health Affairs* 34, no. 7 (July). https://doi.org/10.1377/hlthaff.2014.1088.

ABOUT THE AUTHOR

Andrea Flynn is a fellow at the Roosevelt Institute, where she researches and writes about race, gender, and economic inequality. She is a coauthor of *The Hidden Rules of Race* (Oxford University Press), which examines the historical and present-day drivers of racial and economic inequality. Flynn teaches courses on reproductive health, economic inequality, and politics at Columbia University's Mailman School of Public Health. Her writing has appeared in the *Washington Post*, *The Atlantic*, *Time*, *Teen Vogue*, *The New Republic*, *Cosmopolitan*, and *Salon*. Flynn received her MPA and MPH from Columbia University. You can follow her on Twitter @dreaflynn.

Rakeen Mabud is a fellow at the Roosevelt Institute, where she works on labor market policies and the future of work. Previously, she was the program director of the Roosevelt Institute's 21st Century Economy and Economic Inclusion programs. Mabud co-authored *Left Behind: Snapshots from a 21st Century Economy* and *Wired: Connecting Equity to a Universal Broadband Strategy*, she is a regular contributor at *Forbes*, and her writing has appeared in *The Guardian*, *The Hill*, and *Teen Vogue*. Mabud holds a PhD in government from Harvard University.

Emma Chessen received her MPH from Columbia University's Mailman School of Public Health, where she studied sociomedical sciences with a focus in sexuality and sexual and reproductive health. She coauthored "Empowering New York Consumers in an Era of Hospital Consolidation," a report produced by MergerWatch and supported by the New York State Health Foundation. Emma holds a BA in health and societies from the University of Pennsylvania.

ACKNOWLEDGMENTS

The authors thank Larry Bartlett, Christine Campos, Ioana Marinescu, Jason Spring, Steph Sterling, Lois Uttley, and Allen Weiss for their feedback and insight. Roosevelt Institute staff Nell Abernathy, Jess Forden, and Victoria Streker all contributed to the project; this issue brief was edited by Kendra Bozarth.

This issue brief was made possible with the generous support of the Robert Wood Johnson Foundation and the Novo Foundation. The contents of this publication are solely the responsibility of the authors.

ABOUT THE ROOSEVELT INSTITUTE

Until the rules work for every American, they're not working. The Roosevelt Institute asks: What does a better society look like? Armed with a bold vision for the future, we push the economic and social debate forward. We believe that those at the top hold too much power and wealth, and that our economy will be stronger when that changes. Ultimately, we want our work to move the country toward a new economic and political system: one built by many for the good of all.

It will take all of us to rewrite the rules. From emerging leaders to Nobel laureate economists, we've built a network of thousands. At Roosevelt, we make influencers more thoughtful and thinkers more influential. We also celebrate—and are inspired by—those whose work embodies the values of both Franklin and Eleanor Roosevelt and carries their vision forward today.

ROOSEVELT INSTITUTE
REIMAGINE THE RULES