

Downsizing Mercy

Catholic Hospital Systems and the Crisis of Pediatric Unit Closures

MAY 2026



OUR PATIENTS. OUR UNION. OUR VOICE.



National Nurses
 Organizing
 Committee



National
 Nurses
 United

Executive Summary

This report focuses on inpatient pediatric unit closures over the ten-year period from 2015 to 2024 at three of the nation's largest Catholic hospital systems: Ascension, CommonSpirit Health, and Trinity Health, which we will refer to as the Catholic Big Three. Over the course of a decade, these three systems closed inpatient pediatric units at rates exceeding the national average, resulting in the highest pediatric unit closure rates among large hospital systems nationally. This makes the Catholic Big Three industry leaders in the downsizing of pediatric health care nationally.

Many of these closures are happening in neighborhoods and areas reliant on Medicaid, where elevated poverty levels are common, but options for alternative pediatric care are rare. The fact that these massive and influential Catholic hospital systems are national leaders in the trend of eliminating hospital care for children, often in areas where it is most needed, is particularly concerning given their stated missions emphasizing care for vulnerable populations. The concentration of closures in low-income and rural areas suggests a misalignment between the nominal missions of these Catholic organizations and the operational decision-making driving these unit closures.



Key Findings

25% of all general acute hospitals with inpatient pediatric units in 2015 had closed them by 2024.

- » **Ascension, CommonSpirit Health, and Trinity Health had higher closure rates than the national average**, with closure rates of **38 percent at Ascension, 34 percent at CommonSpirit Health, and 26 percent at Trinity.**
- » Over the period from 2015 to 2024, **these three systems ranked highest for pediatric closure rates, placing first through third among the ten largest hospital systems in the country.**

The Catholic Big Three's closures were concentrated in vulnerable communities.

- » 65 percent of closures occurred in neighborhoods or areas with patients with above-average Medicaid reliance.
- » 69 percent of closures were in high-poverty areas.

These closures are not driven by financial distress.

- » Most hospitals that eliminated their pediatric units were profitable: 67 percent had a positive net income.
- » 78 percent of Ascension, 64 percent of CommonSpirit Health, and 86 percent of Trinity Health facilities that closed pediatric units were profitable.

These closures are creating pediatric care deserts.

- » 58 percent of closures occurred where there was one or no alternative pediatric hospital within 30 miles.

These patterns suggest these systems are using their increasing market power to consolidate and close pediatric services in states across the U.S. **Pediatric cuts are increasing care-access burdens on families and children.**

- » Many closures force families to travel over 20 additional miles or 30 additional minutes to get to the nearest hospital with an inpatient pediatric unit.
- » These additional travel burdens are being imposed on communities with less resources to overcome them, often in times when every second counts for a patient.

The cutting of pediatric hospital care by Catholic hospital systems continues the trend identified in an earlier report by National Nurses United (NNU), highlighting the elevated closure rates of labor and delivery units by Ascension Health, titled ***Dangerous Descent: How Ascension Betrays its Mission by Gutting Care for Pregnant Patients and Babies***¹

- » At Catholic hospitals across the country, parents and children are seeing necessary services shut down by companies violating their own missions.

Introduction

Although pediatric hospitalizations in the United States have declined in recent years, children's overall health outcomes are worsening compared to children in peer nations.² These declining hospitalization numbers and worsening patient outcomes are occurring as hospitals, particularly those operated by large multi-hospital health care systems, are closing pediatric inpatient units and reducing access to essential care. These closures are not evenly distributed and disproportionately affect low-income communities, both urban and rural, contributing to widening health inequities across race, class, and geography.

Rather than a reflection of declining need, the closure of pediatric inpatient units is the result of structural shifts in health care delivery. Financial incentives, especially profit, play a central role in these decisions, as pediatric services generate lower profit margins due to higher reliance on Medicaid reimbursement and fewer high-revenue procedures when compared to adult care.

Our research highlights the closures over a ten-year period from 2015 to 2024 at three large Catholic hospital systems: Ascension, CommonSpirit Health, and Trinity Health (the Catholic Big Three). This includes closures that took place during and after the Covid-19 pandemic.



All three systems maintain that they prioritize caring for the poor and underserved. Even a rudimentary reading of their mission statements would support maintaining essential services such as pediatric inpatient units. Yet our analysis shows that, among the nation's largest hospital systems, the Catholic Big Three had the highest closures rates of pediatric units in the country.

Furthermore, the majority of the pediatric units shuttered by the Catholic Big Three were located in high poverty urban or rural areas with elevated rates of Medicaid coverage, and most were also located in areas with few or no alternatives for inpatient pediatric care.

Our findings also show that the majority of closures occurred at hospitals that remained in operation and reported positive net incomes, indicating that financial distress and insolvency are not the root causes of pediatric unit closures.

These closures have critically harmed the children, families, and communities in which they occurred.

The elimination of inpatient pediatric units directly affects the distances children need to travel to receive care, in many cases leading to the emergence of pediatric care deserts, locations where children and families face significant barriers to accessing timely hospital-based care. Travel distance has long been regarded as a barrier to accessing timely and effective care, most obviously in emergency care, but the implications are much broader. Increased distances also increase the chance of risk during transport. Additionally, higher travel burdens and the closures more broadly mean families face greater financial strain, reduced caregiver involvement in care, and added emotional stress.³ These are all complicating factors for providing care.

As with closures of other types of hospital units, research indicates that pediatric inpatient unit shutdowns are not evenly distributed. Instead, they disproportionately affect rural communities, amplifying geographic disparities in health outcomes and leaving some areas without reasonable access to inpatient pediatric services at all.⁴



Ascension, CommonSpirit Health, and Trinity Health are all rooted in Catholic traditions and, in writing, emphasize service to the most vulnerable populations and community health. Indeed, each system's mission statement explicitly states these guiding values.⁵ Unfortunately, but predictably, these mission statements do not translate into daily operational decisions, specifically regarding pediatric unit closures, labor and delivery unit closures⁶, charity care⁷, and investments.⁸

While costs associated with pediatric hospitalizations have risen, these services only account for a small fraction of a typical hospital's revenue.⁹ Ultimately, the inability to generate revenue is what makes many types of units, including pediatric units, targets for elimination in the single-minded pursuit of profits.

Previous research supports our findings, indicating an on-going trend in hospitals eliminating pediatric beds or entire pediatric units.^{10,11}

The widespread closure of pediatric units points to the larger structural shifts characterizing health care and its provision in the United States today, where hospitals have ensconced a framework that focuses on profit over patient care. This pursuit of profit is reflected in other industry priorities such as hospital consolidations, increased use of telehealth and artificial intelligence, the push for health care in the home, and the national nurse staffing crisis.

The Catholic Big Three hospital systems highlighted in this report each operate 90 or more hospitals around the country and are all considered to be among the top ten largest hospital systems (by number of facilities) in the country.

Likewise, each is founded on Catholic teachings and espouses care and healing for all, connecting to a centuries-old tradition of Catholic health care provision origination in the work of Jesus Christ himself, who instructed his disciples to heal the sick.

Despite this history and the significant opportunities available to continue their missions, the chief executive officers and directors on the boards at these institutions behave in a manner that indicates they value financial incentives over the health care needs of children, warping the historic role of Catholic church as one of the world's largest non-governmental health care providers for the sake of financial gains.

It is our conclusion that these three hospital systems must realign their work with their missions and the historic role of Catholicism in building and operating health care infrastructure. To do so, they must implement systemwide changes to reopen closed pediatric units, commit to providing pediatrics at all newly built or acquired facilities, and ensure that pediatric inpatient units everywhere are fully and safely staffed. This will ensure the health and wellbeing of children, families, and communities around the country.



Our socioeconomic analysis used American Community Survey (ACS) five-year data from the U.S. Census Bureau, 2020-2024, utilizing Esri ArcGIS to map hospital locations to census tract and county shapefiles. Similarly, our analysis finding the distance between and around closed inpatient pediatric facilities utilized Esri ArcGIS Find Closest analysis.

Discussion of findings

Access to pediatrics is a matter of life and death

Access to pediatric inpatient units is not simply a matter of convenience. It can be a matter of life and death. When a hospital has no pediatric beds, children are often directed to emergency room (ER) departments¹² with long wait times. Once in the ER, many pediatric patients then require transfers to other hospitals to be able to receive appropriate care. These delays are not harmless. Each delay in care increases the likelihood that the child's condition will worsen.

Research has shown that the likelihood of a hospital fully treating a child without transfer to another facility has dropped dramatically when compared to adults, reflecting how constrained pediatric care has become over the last two decades.¹³ Even for common conditions such as asthma, croup, or seizures, children are increasingly channeled through emergency departments and then transferred to a limited number of specialized hospitals. Each additional step and delay during waiting, transferring, and re-triaging introduces time-sensitive risks that can ultimately affect patient outcomes, including survival and recovery.¹⁴

Despite the well-known damaging consequences of closing inpatient pediatric units, our research indicates that, nationwide, 25 percent of the 1,307 general acute hospitals operating inpatient pediatric units in 2015 had closed those units by 2024. Over the ten-year period, hospitals systems closed 331 pediatric units, a rate of more than 33 shutdowns each year. These closures had a broad geographic impact, located across 46 states and in a mix of rural and urban areas. They included 45 critical access hospitals, 25 rural referral centers, and 30 sole community providers.¹⁵

Methods

Our research examines the closure of inpatient pediatric units at general acute hospitals over the ten-year period from 2015 to 2024. We identified facilities operating pediatric units using data from the 2015 American Hospital Association (AHA) Annual Survey, defining pediatric inpatient units as hospitals with the service type “general medical and surgical” and reporting one or more inpatient pediatric bed. We considered units closed if the pediatric beds were changed to zero in the 2024 AHA Annual Survey. All hospital types other than “general medical and surgical” were excluded from this analysis, as well as all hospitals that did not report data for pediatric beds.

Likewise, our analysis of the role of hospital systems in closing pediatric units is based on system data found in the AHA Annual Survey. To calculate the closures of CommonSpirit Health, which was formed in 2019 by the merger of Catholic Health Initiatives and Dignity Health, we combined the data for its two predecessor organizations in the 2015 AHA Annual Survey, so that the system data in 2015 would align with the 2024 system data.

To measure the continued operation and net income levels of hospitals closing pediatric units, we relied on Medicare Cost Report data.

Hospitals owned by health care systems operating multiple facilities closed their pediatric units at a higher rate than those that remained independently operated. While system-owned hospitals closed 27 percent of their pediatric units, independent hospitals only closed 23 percent.

Among the ten hospital systems with the highest number of inpatient pediatric units in 2015, listed in Table 1, the nation’s largest Catholic hospital organizations (the Catholic Big Three) were the top systems in eliminating inpatient care for children, as measured by the rate or percentage of unit closures.

» **Ascension** had the highest closure rate, closing 38 percent of its pediatric units. This included pediatric closures at three critical-access hospitals and at a hospital designated as a rural referral center.

» **CommonSpirit Health** had the second highest shutdown rate, closing 34 percent of its units, including two at hospitals designated as rural referral centers.

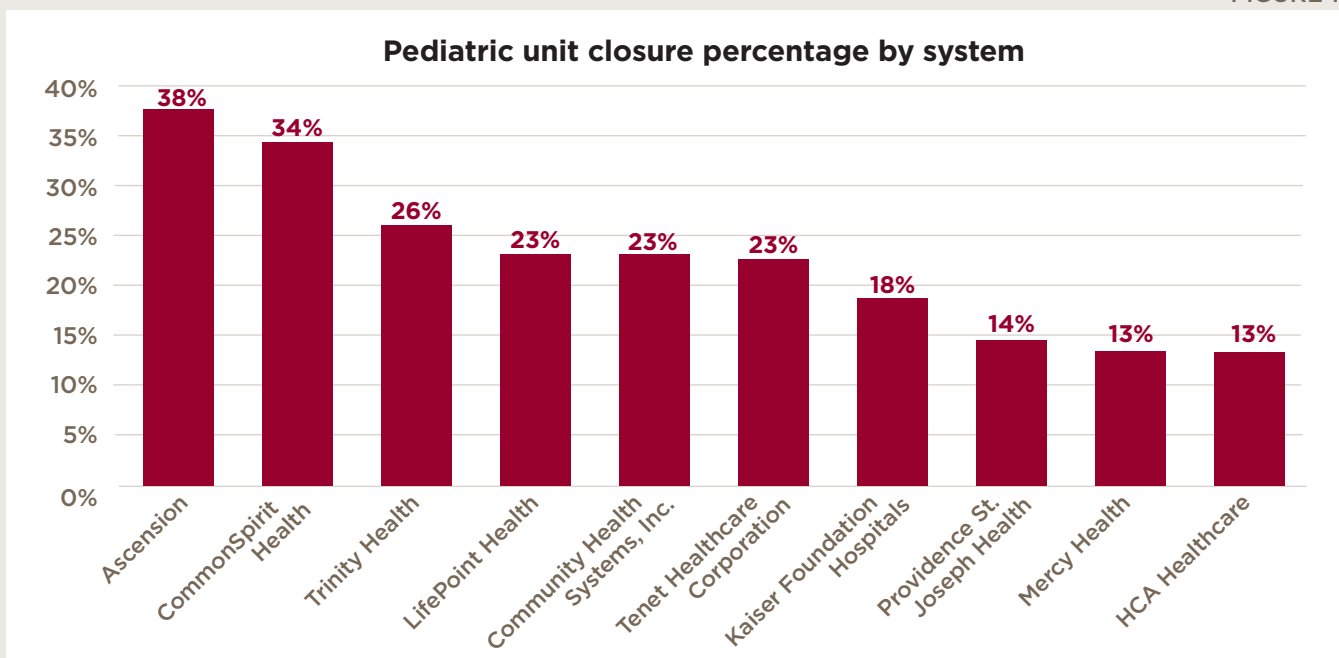
» **Trinity Health** had the third highest rate, closing 26 percent of its pediatric units, including one at a hospital designated as a rural referral center.

Largest hospital systems by number of inpatient pediatric units in 2015, in order of closure percentage by 2024

TABLE 1.

| SYSTEM NAME | GENERAL ACUTE HOSPITALS WITH PEDIATRIC UNITS <i>as of 2015</i> | PEDIATRIC UNIT CLOSURES <i>as of 2024</i> | PEDIATRIC UNIT CLOSURE PERCENTAGE BY SYSTEM |
|--|---|--|--|
| Ascension | 24 | 9 | 38% |
| CommonSpirit Health (CHI plus Dignity) | 32 | 11 | 34% |
| Trinity Health | 23 | 6 | 26% |
| LifePoint Health | 13 | 3 | 23% |
| Community Health Systems, Inc. | 48 | 11 | 23% |
| Tenet Healthcare Corporation | 22 | 5 | 23% |
| Kaiser Foundation Hospitals | 11 | 2 | 18% |
| Providence St. Joseph Health | 14 | 2 | 14% |
| Mercy Health | 15 | 2 | 13% |
| HCA Healthcare | 32 | 4 | 13% |

FIGURE 1.



Ascension, CommonSpirit Health, and Trinity pediatric closures are not driven by financial distress

Our research indicates that closures of pediatric units are not generally driven by financial distress or insolvency. This is shown by the fact that 94 percent of facilities that cut pediatric units remained in operation and continued offering other services. Using Medicare Cost Report data, we found that, of the 331 hospitals that closed their inpatient pediatric units, 311 submitted a Medicare Cost Report in 2024, indicating they were still in operation.

Additionally, more than two-thirds of the hospitals with pediatric closures were profitable. Among the 331 hospitals that closed inpatient pediatrics units, 67 percent reported receiving a positive net income in 2015, with an average profit of \$9.8 million, indicating that most facilities were not experiencing financial distress or crisis.

This dynamic was especially true for the Catholic Big Three. Among the 24 Ascension hospitals that closed pediatric units in our study, only two did not realize a profit in 2015. Among Trinity hospitals that closed their units, all but one brought in millions in profits in 2015. Finally, 64 percent of the CommonSpirit Health hospitals with pediatric closures saw profits in that year.

See Appendix for a list of pediatric closures by Ascension, CommonSpirit Health, and Trinity Health and the 2015 net incomes for those hospitals.

The Catholic Big Three are closing pediatrics in low-income communities

Our findings indicate that many of the closures are disproportionately concentrated in low-income communities, the precise areas where children already face higher health risks, have fewer health care resources, and that the Catholic Big Three espouse to serve.

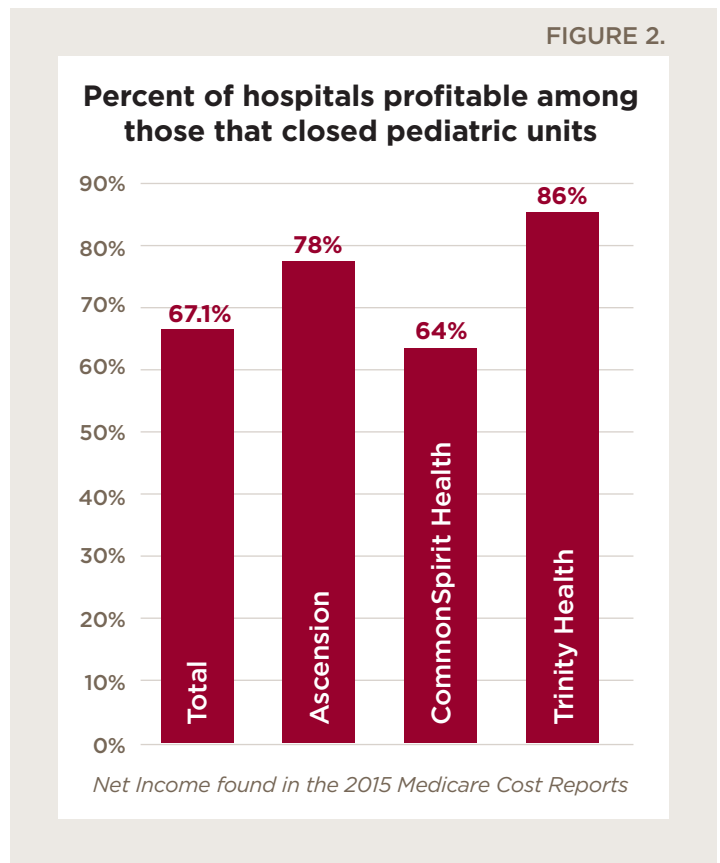
Comparing the poverty rates in areas with shuttered pediatric units to broader state levels is illuminating. For Ascension, 56 percent of pediatric closures took place in areas with poverty rates higher than the state level. That percent was higher for CommonSpirit Health, which had 64 percent of its closures take place in such areas. Trinity Health was the worst of the three, with 83 percent of pediatric closures in areas with poverty rates higher than the state level.

See Appendix for a list of pediatric closures by Ascension, CommonSpirit Health, and Trinity Health and a high poverty designation for those hospitals.

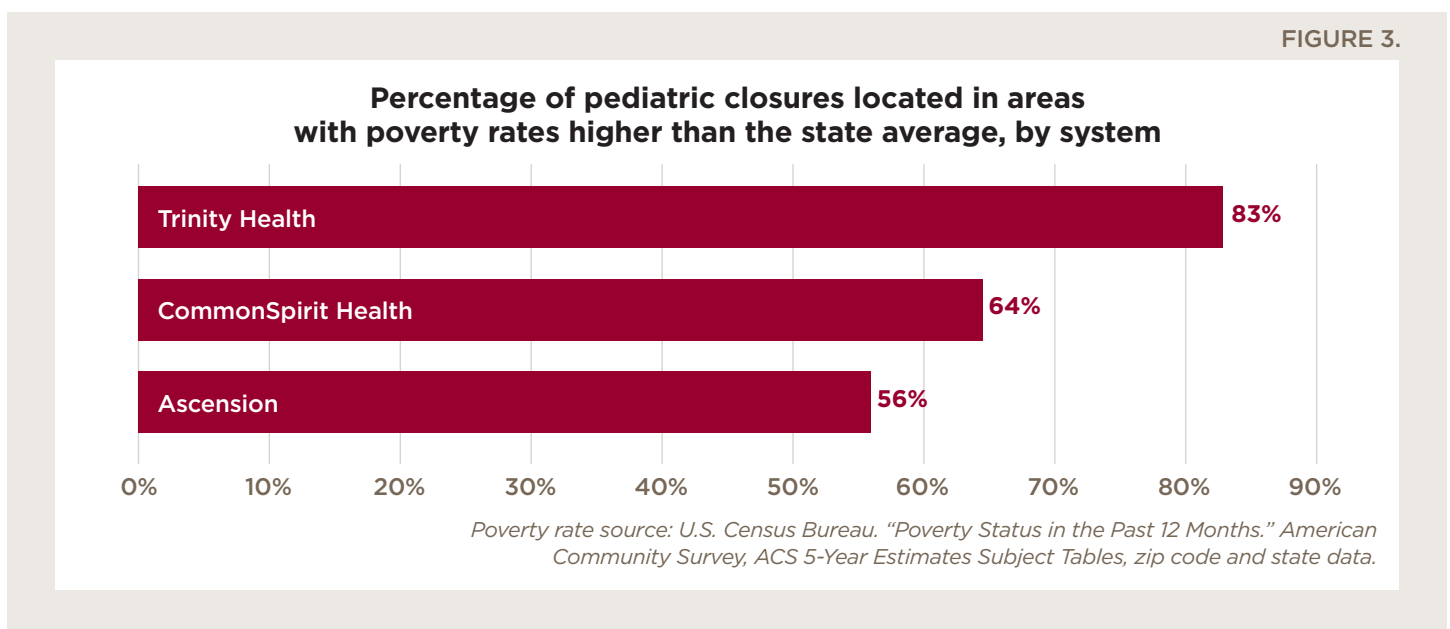
In addition, 46 percent of the closures took place in areas where the portion of the population lacking health insurance exceeded the national level, including parts of Polk County, Texas; Randolph County, Indiana; and Cook County, Illinois, where the percentage of children without health insurance exceeds 20 percent. Of children who do have health insurance, our analysis indicated that these hospital patients were disproportionately reliant on Medicaid, finding that 17 out of 26 closures took place in census tracts with Medicaid participation rates higher than the 2024 national average of 34.2 percent.

Medicaid is generally the major payer for pediatric hospitalizations, with the highest proportion of these payments being in low-income urban and rural areas. Typically, Medicaid reimburses at lower rates than private insurance or Medicare, making pediatric services far less financially lucrative than adult services. Furthermore, pediatric care generally generates less revenue than adult care because children require fewer high-margin procedures (such as elective procedures and advanced imaging).^{16,17}

Research also indicates that children of color frequently have access to and receive worse health care than white children.¹⁸ These hospital systems are actively exacerbating longstanding racial inequities with their closures. Our analysis shows that 12 of the 26 pediatric unit closures at Catholic Big Three hospitals occurred in neighborhoods where the proportion of Black, Latine, and other people of color is higher than in the surrounding county.



The link between poverty and worse child health has long been established, including outcomes like higher rates of chronic illness, unmet health care needs, and increased mortality. When pediatric units close in low-income areas, it disproportionately affects populations that are already medically and socioeconomically vulnerable, deepening existing inequities in access to care. This underscores the imperative for pediatric inpatient care in these settings, further underscoring the harm done by these shutdowns.



Ascension, CommonSpirit Health, and Trinity Health are closing pediatrics in areas with few or no alternatives for patients but high market concentration for these systems

Among the pediatric units closed by the Catholic Big Three, 58 percent occurred in regions where there are one or zero alternative hospitals offering inpatient pediatrics within 30 miles. These closures result in diminished local capacity and increased travel times for patients.

Closures of pediatric units with zero or one pediatric-capable facility within 30 miles

TABLE 2.

| HOSPITAL NAME (2024) | SYSTEM NAME AT TIME OF PEDIATRIC UNIT CLOSURE | COUNTY | STATE |
|---|---|-----------------|------------|
| Aspirus Stevens Point Hospital | Ascension | Portage County | Wisconsin |
| CHI St. Joseph Regional Health Center | CommonSpirit Health | Brazos County | Texas |
| St. Luke’s Health - Memorial Livingston | CommonSpirit Health | Polk County | Texas |
| Sierra Nevada Memorial Hospital | CommonSpirit Health | Nevada County | California |
| St. Peter’s Hospital | Trinity Health | Albany County | New York |
| St. Mary’s Hospital Athens | Trinity Health | Clarke County | Georgia |
| Ascension St. John Medical Center | Ascension | Tulsa County | Oklahoma |
| Ascension All Saints | Ascension | Racine County | Wisconsin |
| Ascension Saint Thomas Hickman | Ascension | Hickman County | Tennessee |
| CommonSpirit - Longmont United Hospital | CommonSpirit Health | Boulder County | Colorado |
| Penrose-St. Francis Health Services | CommonSpirit Health | El Paso County | Colorado |
| CommonSpirit - St. Mary-Corwin Hospital | CommonSpirit Health | Pueblo County | Colorado |
| Saint Alphonsus Regional Medical Center | Trinity Health | Ada County | Idaho |
| UnityPoint Health-St. Luke’s-Downtown | Trinity Health | Woodbury County | Iowa |
| Saint Alphonsus Medical Center - Nampa | Trinity Health | Canyon County | Idaho |

See Appendix for additional details on pediatric closures by Ascension, CommonSpirit Health, and Trinity Health.

In states where CommonSpirit Health has substantial market power, it appears it is using its scale to slash pediatric services. CommonSpirit Health's closures in Colorado, where the system is among the largest in the state, have been especially alarming. Since 2014, CommonSpirit Health-affiliated facilities have closed three inpatient pediatric units. Young patients at CommonSpirit Health's Longmont United Hospital now must travel dozens of miles to receive care. The closest inpatient pediatric facility is over 35 miles and around an hour by car.

Similarly, CommonSpirit Health closed three pediatric facilities in Texas, including two in the Houston health care market. Since CommonSpirit Health shuttered care at two facilities, St. Luke's Health - Memorial Livingston and St. Luke's Health - The Woodlands Hospital, patients now must travel an additional 50 miles and 21 miles, respectively. In California, where CommonSpirit Health has long been one of the largest health systems in the state, management closed Sierra Nevada Memorial Hospital's inpatient pediatric unit, and the nearest hospital offering inpatient pediatric care is 40 miles away.

Ascension has used its scale in states where it has a large presence to similar effect. NNU's 2024 report *Dangerous Descent: How Ascension Betrays its Mission by Gutting Care for Pregnant Patients and Babies*¹⁹ found that Ascension was using its market power in the Indianapolis, Indiana, area to shutter obstetrics units. This report finds that Ascension is also closing pediatric units in the same area. Ascension, one of the largest hospital systems in the state, eliminated pediatric services at St. Vincent Randolph and St. Vincent Mercy, forcing young patients and their families to travel over 20 additional miles for care. In Tennessee, where Ascension has 16 hospitals, it closed its pediatric services at Ascension Saint Thomas Hickman Hospital, while the nearest inpatient pediatric unit is 30 miles away.

Trinity has used the relative geographic proximity of its facilities to consolidate care. In 2023, Trinity discontinued pediatric services at Gottlieb Memorial Hospital, effectively consolidating care at Trinity's Loyola University Medical Center, almost a 20-minute drive away. Gottlieb Memorial Hospital resides in a census tract with 45 percent of children on Medicaid, higher than both the national average and the surrounding county, where 35 percent of children are on Medicaid.

See Appendix for a full list of pediatric closures by Ascension, CommonSpirit Health, and Trinity Health.

The creation of pediatric care deserts through regionalization

Pediatric unit closures are accelerating the regionalization of pediatric care and altering how children in rural areas access and receive hospital care, intensifying the consequences of these shutdowns. When a pediatric unit closes in a major metropolitan area, families may still have access to other large pediatric centers, even though they may have to deal with increasing delays and transportation challenges.²⁰ In rural regions, the closure of a hospital's pediatric unit often leaves families with no other proximate options.²¹

Between 2002 and 2017, hospitalizations for rural-residing children declined by more than 50 percent. At the same time, reliance on interfacility transfers increased almost fourfold, rising from 6.7 percent to 26.5 percent. Meanwhile, that same timeframe saw children receiving care close to home fall from over half to just one-fifth, while the proportion of children hospitalized in metropolitan areas relative to rural areas rose dramatically.²²

This shift is indicative of both declining local capacity and broader structural changes in health care and its delivery, where services are increasingly concentrated in affluent metropolitan neighborhoods.

The end result is pediatric care deserts created and left behind by these hospital systems. For many children and families, the consequences are devastating. Further travel distances saddle families with added logistical, financial, and emotional burdens that can contribute to missed work, school absences, and delayed care-seeking. In addition, the lack of local pediatric services may lead clinicians to manage more severe conditions outside of hospital settings. These pediatric care deserts are not just worsening health outcomes, they are exacerbating health inequities.^{23,24}

Catholic health care: Prioritizing money while neglecting the most vulnerable

The closure of pediatric units in general acute hospitals has often been blamed on financial pressures, low patient volume, and staffing shortages.²⁵ Indeed, many health care systems maintain that, because the number of pediatric patients has declined over recent decades, maintaining equipment and beds for children is simply not financially feasible. But the stated objective of financial feasibility is fundamentally at odds with a national health care landscape where hospital executives continue to be compensated with salaries exceeding six figures.

This is true at the three Catholic hospital systems that are the focal point of this study. In fact, over the last five years, CommonSpirit Health paid over \$595 million total to a just few dozen of its executives. Over the same period, Ascension paid its top executives \$166 million, and Trinity Health paid its corporate leaders \$142 million.²⁶

The systems' net income figures also prompt suspicion about their financial feasibility claims. Over the last eight years, CommonSpirit Health has reported an aggregate \$14.1 billion in net income. In just the last year alone, CommonSpirit Health brought in \$1.1 billion in net income, Ascension brought in \$1.2 billion in net income, and Trinity Health reported its 2025 net income as \$1.4 billion.²⁷ Clearly, financial distress or capital shortages are not the forces driving these closures.

Each of these the Catholic Big Three health systems maintains a mission championing service to vulnerable populations and communities, nominally in line with teachings of the Catholic Church that "accessing health care is 'a fundamental right of every human being.'"²⁸ And yet, the operational practices of these systems, including reductions and eliminations to services and staffing, indicate these companies are operating based on a very different set of values. Prioritizing revenue-generating services over lower-margin but essential care, such as pediatrics, highlights that they are no longer mission-driven, but instead profit-driven.



As hospital mergers and acquisitions continue to shape the health care landscape, this is of crucial importance. Today, one in six hospital beds in the United States is at a Catholic hospital.^{29,30} As this report and other research demonstrates, communities cannot assume that these systems will actually carry out their stated mission, despite being rooted in Catholic teachings and, in many cases, originally founded by clergy who embodies the values that the Catholic Big Three are effectively abdicating.

This dissonance between Catholic hospitals' history and their modern operation is evident in the fact that these hospitals, as a group, have been found to serve a lower percentage of Medicaid-insured patients than non-Catholic hospitals. While 7.2 percent of all discharges at Catholic hospitals were Medicaid patients, the Medicaid discharge rate was 8.3 percent at non-profit hospitals and 13.6 percent at public hospitals.³¹

Additionally, Catholic hospitals were found to provide slightly less charity care.³² This is perhaps among the most glaring examples of the space between Catholic health care systems' stated missions and their actual operations.

As Catholic systems continue to grow and acquire more facilities in the pursuit of on-going market consolidation, they will undoubtedly continue their pursuit of profit maximization, unless action is taken to motivate them to re-embrace Catholic health care's actual values.

Conclusion and recommendations

The abandonment of children by Ascension, CommonSpirit Health, and Trinity Health is an intentional act that has profound consequences for children's health, particularly those who live in rural and urban low-income areas. Despite their Catholic mandates and their stated missions to help the vulnerable in their communities, Catholic health care systems are instead weakening local care capacities, accelerating profit-driven regionalization, and intensifying health inequities along geographic, race, class, and other key socioeconomic divides.

To put it plainly, these systems are pursuing profits at the expense of children's health. As some of the largest hospital systems in the United States overall, their practices and influence set standards that shape the landscape of health care in this country and globally.

Similarly sized secular and for-profit competitor systems may have less moral virtue to hide their profit-first operational strategies behind. But the moral virtue of the Catholic Big Three systems highlighted in this report also carries complicated operational considerations, as they have been granted nonprofit status and thus are awarded hundreds of millions of dollars in tax breaks that ultimately benefit their business operations, not their patients.

As the largest union of registered nurses in the country, National Nurses United and affiliate National Nurses Organizing Committee urge the adoption of the following recommendations to create serious systemic changes and ensure that these systems operate in accordance with their actual missions:

- 1. Listen to nurses at the bedside and the bargaining table and safely staff every unit to ensure the best care for patients.**
- 2. Commit to reopening closed pediatric units.**
- 3. Provide pediatric services at all new hospitals opened or acquired by Ascension, CommonSpirit Health, or Trinity Health.**

The closures of pediatric units in general acute hospitals reflects a broader problem regarding priorities within the U.S. health care system. As financial incentives drive health care decision-making and policymakers fail to enact meaningful legislation to preserve quality care, we call on the Catholic Big Three to live by their mandated missions and put the needs of the children and communities above hospital profits.

If the nation's largest not-for-profit Catholic hospital systems want to actually make clear that the most vulnerable are their priority, that commitment must be reflected in the way they operate on a daily basis.

Endnotes

- 1 National Nurses United, 2023. "Dangerous Descent: How Ascension Betrays its Mission by Gutting Care for Pregnant Patients and Babies" https://www.nationalnursesunited.org/sites/default/files/nnu/documents/1223_AscensionSeton_Obstetrics_DangerousDescent_Report.pdf
- 2 Lytchakov, Anna J., Nathan M. Money, Jennifer A. Hoffmann, Todd A. Florin, Kenneth A. Michelson, and Sriram Ramgopal. 2026. "Prevalence and costs of US Pediatric Hospitalizations, 2022." *Hospital Medicine*. <https://doi.org/10.1002/jhm.70272> and Agency for Healthcare Research and Quality. <https://hcup-us.ahrq.gov/reports/statbriefs/sb299-Hospital-Stays-Children-2019.jsp>; and Forrest, Christopher B., Lauren J. Koenigsberg, Francis Eddy Harvey, Mitchell G. Maltenfort, and Neal Halfon. 2025. "Trends in US Children's Mortality, Chronic Conditions, Obesity, Functional Status, and Symptoms." *JAMA*. 334(6):509-516; and Wolf, Steven and Derek A. Chapman. 2024. "Excess US Deaths Attributable to High All-Cause Mortality Rates Among Youths Aged 0 to 19 Years." *JAMA Pediatrics*. 178(9):942-944. Agarwal, Maneesha. 2025. "As Pediatric Capabilities Shrink, Family Strain Grows." AAP Journals Blog
- 3 Agarwal, Maneesha. 2025. "As Pediatric Capabilities Shrink, Family Strain Grows." AAP Journals Blog. <https://publications.aap.org/journal-blogs/blog/33951/As-Pediatric-Capabilities-Shrink-Family-Strain>
- 4 Cushing, Anna M., Emily M. Bucholz, Alyna T. Chien, Daneil A. Rauch, and Kenneth A. Michelson. 2021. "Availability of Pediatric Inpatient Services in the United States." *Pediatrics*. 148(1):e2020041723
- 5 **Ascension mission statement:** "Rooted in the loving ministry of Jesus as healer, we commit ourselves to serving all persons with special attention to those who are poor and vulnerable. Our Catholic health ministry is dedicated to spiritually centered, holistic care which sustains and improves the health of individuals and communities. We are advocates for a compassionate and just society through our actions and our words." **CommonSpirit mission statement:** "As CommonSpirit Health, we make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all." **Trinity Health mission statement:** "We, Trinity Health, serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities"
- 6 National Nurses United, 2023. "Dangerous Descent: How Ascension Betrays its Mission by Gutting Care for Pregnant Patients and Babies" https://www.nationalnursesunited.org/sites/default/files/nnu/documents/1223_AscensionSeton_Obstetrics_DangerousDescent_Report.pdf

- 7 Rachana Pradhan, Sept. 12, 2024. "At Catholic Hospitals, a Mission of Charity Runs Up Against High Care Costs for Patients." KFF Health News. <https://kffhealthnews.org/health-care-costs/catholic-hospitals-charitable-mission-high-care-costs/>
- 8 National Nurses United, 2025. "Rejecting the Call: How Ascension's Unethical and Socially Irresponsible Investments Contravene Catholic Social Teaching." <https://www.nationalnursesunited.org/press/ascension-health-investments-appear-to-reject-vatican-guidance>
- 9 Lytchakov, Anna J., Nathan M. Money, Jennifer A. Hoffmann, Todd A. Florin, Kenneth A. Michelson, and Sriram Ramgopal. 2026. "Prevalence and costs of US Pediatric Hospitalizations, 2022." Hospital Medicine. <https://doi.org/10.1002/jhm.70272>
- 10 According to a study published in 2024 in the Journal of the American Medical Association, during the period from 2008 and 2022, the number of pediatric inpatient units decreased by nearly 30 percent. This was accompanied by a substantial reduction in available pediatric beds. In fact, more than 40 percent of pediatric inpatient units that were ever operational had closed by 2022. This decline far outpaced changes observed in adult inpatient services, which remained relatively stable over the same period. (Michelson, Kenneth A., Anna M. Cushing, and Emily M. Bucholz. 2024. "National Trends in Pediatric Inpatient Capacity." JAMA Pediatrics. 179(2):208-209)
- 11 Michelson, Kenneth A., Anna M. Cushing, and Emily M. Bucholz. 2024. "National Trends in Pediatric Inpatient Capacity." JAMA Pediatrics. 179(2):208-209; and San Soucie, Carolyn M., Nancy D. Beaulieu, Jason D. Buxbaum, David M. Cutler, JoAnna K. Leyenaar, Sarah C. McBride, Olivia Zhao, and Alyna T. Chien. 2024. "A National Analysis of General Pediatric Inpatient Unit Closures and Openings, 2011 – 2018." Hospital Pediatrics. 14(11).
- 12 Miller, B. "Pediatrics and profits: Why children's hospital units are closing," The Lown Institute. December 5, 2022. <https://lowninstitute.org/pediatrics-and-profits-why-childrens-hospital-units-are-closing/>
- 13 Cushing, Anna M., Emily M. Bucholz, Alyna T. Chien, Daniel A. Rauch, and Kenneth A. Michelson. 2021. "Availability of Pediatric Inpatient Services in the United States." Pediatrics. 148(1): e2020041723
- 14 Michelson, Kenneth A., Anna M. Cushing, and Emily M. Bucholz. 2024. "National Trends in Pediatric Inpatient Capacity." JAMA Pediatrics. 179(2):208-209; and Mahant, Sanjay and Astrid Guttman. 2023. "Shifts in the Hospital Care of Children in the US – A Health Equity Challenge." JAMA Network Open. 6(9):e2331763; and Geoff Bennett, 2022. "What's behind an increase in closures of pediatric units." PBS News. Oct 15, 2022 <https://www.pbs.org/newshour/show/whats-behind-an-increase-in-closures-of-pediatric-units>
- 15 A **Critical Access Hospital** is a designation from Centers for Medicare and Medicaid Services (CMS) for eligible rural hospitals intended to preserve access to healthcare in underserved rural communities. (<https://www.cms.gov/medicare/health-safety-standards/certification-compliance/critical-access-hospitals>)
A **Rural Referral Center** is a CMS designation for hospitals defined as high-volume acute care rural hospitals that treat a large number of complicated cases. (<https://www.hrsa.gov/opa/eligibility-and-registration/hospitals/rural-referral-centers>)
A **Sole Community Provider** is a hospital recognized by CMS as the primary source of inpatient hospital services for a geographic area
- 16 Leyenaar JK, Freyleue SD, Arakelyan M, Goodman DC, O'Malley AJ. Pediatric Hospitalizations at Rural and Urban Teaching and Nonteaching Hospitals in the US, 2009-2019. JAMA network open. 2023;6(9):e2331807-e2331807. doi:10.1001/jamanetworkopen.2023.31807
- 17 Miller, Brenna. 2022. "Pediatrics and Profits: Why Children's Hospital Units are Closing." Lown Institute. <https://lowninstitute.org/pediatrics-and-profits-why-childrens-hospital-units-are-closing/>
- 18 Slopen N, Chang AR, Johnson TJ, Anderson AT, Bate AM, Clark S, Cohen A, Jindal M, Karbeah J, Pachter LM, Priest N, Suglia SF, Bryce N, Fawcett A, Heard-Garris N. Racial and ethnic inequities in the quality of paediatric care in the USA: a review of quantitative evidence. Lancet Child Adolesc Health. 2024 Feb;8(2):147-158. doi: 10.1016/S2352-4642(23)00251-1. PMID: 38242597; PMCID: PMC11841375
- 19 National Nurses United, 2023. "Dangerous Descent: How Ascension Betrays its Mission by Gutting Care for Pregnant Patients and Babies" https://www.nationalnursesunited.org/sites/default/files/nnu/documents/1223_AscensionSeton_Obstetrics_DangerousDescent_Report.pdf
- 20 For example, in Boston in 2022, Tufts Medical Center closed the pediatric unit. While this has been devastating for patients, families and the community, it remains that Boston Children's Hospital or Hasbro Children's Hospital are within the same metropolitan area
- 21 Baumgaertner, E. "As Hospitals Close Children's Units, Where Does That Leave Lachlan?" The New York Times, October 11, 2022. <https://www.nytimes.com/2022/10/11/health/pediatric-closures-hospitals.html>
- 22 McDaniel, Corrie E., Matt Hall, and Jay G. Berry. 2026. "Hospitalization Patters for Rural-Residing Children from 2002 to 2017." Academic Pediatrics. 25(1): 102554.
- 23 Mahant, Sanjay and Astrid Guttman. 2023. "Shifts in the Hospital Care of Children in the US – A Health Equity Challenge." JAMA Network Open. 6(9):e2331763
- 24 McDaniel, Corrie, Matt Hall, and Jay G. Berry. 2023. "Trends in Distance Traveled for Common Pediatric Conditions for Rural-Residing Children." JAMA Pediatrics. 178(1):80-81
- 25 Ho, Catherine. "North Bay Hospital to Close Pediatric Unit, Sending Kids Hours Away for Care." San Francisco Chronicle, 12/19/2025. <https://www.sfchronicle.com/health/article/santa-rosa-pediatric-closure-21251147.php>
- 26 Executive compensation figures were taken from the 990 IRS Forms, found at ProPublica Nonprofit Explorer: <https://projects.propublica.org/nonprofits/>
- 27 All net income data found in audited financial statements found at ProPublica Nonprofit Explorer: <https://projects.propublica.org/nonprofits/>
- 28 O'Loughlin, Michael J. 2024. "When a Catholic Hospital Becomes For-Profit." America. <https://www.americamagazine.org/faith/2024/05/16/catholic-hospitals-profit-mission-247913/>
- 29 Sanders, Bailey, Barak Richman, and Kierra B. Jones. 2025. "Growing Market Power Among Catholic Hospitals Restrains Access to Reproductive Health Care." Center for American Progress. <https://www.americanprogress.org/article/growing-market-power-among-catholic-hospitals-restrains-access-to-reproductive-health-care/>
- 30 Nguyen, Quynh Chi and Michelle Strenthal. 2025. "The Hidden Harm of Catholic Hospitals: Why We Must Take Action." Community Catalyst. <https://communitycatalyst.org/posts/the-hidden-harm-of-catholic-hospitals-why-we-must-take-action/>
- 31 Solomon, Tess, Lois Uttley, Patty HasBrouck, and Yoolim Jung. 2020. "Bigger and Bigger: The Growth of Catholic Health Systems." Community Catalyst. <https://communitycatalyst.org/wp-content/uploads/2022/11/2020-Cath-Hosp-Report-2020-31.pdf>
- 32 Solomon, Tess, Lois Uttley, Patty HasBrouck, and Yoolim Jung. 2020. "Bigger and Bigger: The Growth of Catholic Health Systems." Community Catalyst. <https://communitycatalyst.org/wp-content/uploads/2022/11/2020-Cath-Hosp-Report-2020-31.pdf>

Appendix:

List of Ascension, CommonSpirit Health, and Trinity Health hospitals that closed inpatient pediatric units

| Hospital name (2024) | System name at time of pediatric unit closure | City | County | State | Net income (or loss) in 2015 | % of Medicaid patients under 19 | Distance to nearest open pediatric unit | Higher poverty rate than state average |
|---|---|-------------------|-----------------|-------|------------------------------|---------------------------------|---|--|
| Henry Ford Genesys Hospital | Ascension | Grand Blanc | Genesee | MI | (\$403,001,507) | 12% | 12 | |
| Ascension Saint Thomas Hickman | Ascension | Centerville | Hickman | TN | (\$1,565,709) | 40% | 30 | |
| Ascension St. Vincent Mercy | Ascension | Elwood | Madison | IN | \$2,033,954 | 64% | 21 | Yes |
| Aspirus Stevens Point Hospital | Ascension | Stevens Point | Portage | WI | \$8,069,321 | 12% | 34 | Yes |
| Henry Ford Providence Southfield Hospital | Ascension | Southfield | Oakland | MI | \$21,603,526 | 51% | 5 | |
| Ascension St. Vincent Randolph | Ascension | Winchester | Randolph | IN | \$2,520,249 | 46% | 23 | Yes |
| Ascension All Saints | Ascension | Racine | Racine | WI | \$48,617,930 | 12% | 30 | Yes |
| Ascension Alexian Brothers | Ascension | Elk Grove Village | Cook | IL | \$58,746,065 | 18% | 7 | |
| Ascension St. John Medical Center | Ascension | Tulsa | Tulsa | OK | \$67,135,464 | 8% | 7 | Yes |
| Sierra Nevada Memorial Hospital | CommonSpirit Health* | Grass Valley | Nevada | CA | (\$14,406,432) | 44% | 40 | Yes |
| CHI St. Joseph Regional Health Center | CommonSpirit Health* | Bryan | Brazos | TX | (\$2,762,775) | 26% | 9 | |
| CommonSpirit - St. Mary-Corwin Hospital | CommonSpirit Health* | Pueblo | Pueblo | CO | (\$2,124,653) | 67% | 4 | Yes |
| Trinity Health System | CommonSpirit Health* | Steubenville | Jefferson | OH | (\$1,339,187) | 81% | 8 | Yes |
| CommonSpirit - Longmont United Hospital | CommonSpirit Health* | Longmont | Boulder | CO | \$1,571,513 | 45% | 35 | Yes |
| St. Luke's Health - Memorial Livingston | CommonSpirit Health* | Livingston | Polk | TX | \$2,937,671 | 39% | 50 | Yes |
| French Hospital Medical Center | CommonSpirit Health* | San Luis Obispo | San Luis Obispo | CA | \$6,045,294 | 16% | 2 | Yes |
| CHI Health Mercy Council Bluffs | CommonSpirit Health* | Council Bluffs | Pottawattamie | IA | \$13,283,112 | 49% | 1 | |
| CHI Health Creighton University Medical Center - Bergan Mercy | CommonSpirit Health* | Omaha | Douglas | NE | \$27,298,371 | 36% | 3 | |
| St. Luke's Health - The Woodlands Hospital | CommonSpirit Health* | The Woodlands | Montgomery | TX | \$13,742,052 | 5% | 21 | |
| Penrose-St. Francis Health Services | CommonSpirit Health* | Colorado Springs | El Paso | CO | \$29,572,876 | 3% | 10 | Yes |
| UnityPoint Health-St. Luke's-Downtown | Trinity Health | Sioux City | Woodbury | IA | (\$8,172,699) | 83% | 3 | Yes |
| Saint Alphonsus Regional Medical Center | Trinity Health | Boise | Ada | ID | \$11,969,697 | 40% | 4 | Yes |
| St. Mary's Hospital Athens | Trinity Health | Athens | Clarke | GA | \$29,248,140 | 43% | 2 | Yes |
| Gottlieb Memorial Hospital | Trinity Health | Melrose Park | Cook | IL | \$7,064,511 | 45% | 5 | Yes |
| Saint Alphonsus Medical Center - Nampa | Trinity Health | Nampa | Canyon | ID | \$15,603,454 | 81% | 22 | |
| St. Peter's Hospital | Trinity Health | Albany | Albany | NY | \$39,144,543 | 34% | 40 | Yes |

*CommonSpirit Health was formed in 2019 by the merger of Catholic Health Initiatives and Dignity Health. For consistency, we combined its two predecessor organizations in 2015 so that the system data in 2015 would align with the 2024 system data.



OUR PATIENTS. OUR UNION. OUR VOICE.

