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My name is Stephen Herzenberg. I have a PhD in economics from MIT and am the executive director of the Keystone Research Center, an independent, non-partisan Pennsylvania research center.

The so-called "eds and meds" economy is at the heart of Pittsburgh's economy in the way that the steel industry was once central. Today, over one out of every seven private sector workers in the region is employed by a hospital, a nursing home, a physician's office, or other health services business.[1]

Within this now-dominant industry, no employers are as significant as Pittsburgh's hospitals, which employ 55,000 people in the Metro Pittsburgh area alone. In fact, by itself, UPMC with its 60,000 employees is the largest private employer in ALL of Pennsylvania and overwhelmingly so in the Pittsburgh area.[2]

With such a large economic footprint, the community impact of hospitals is unrivaled. It just matters more what hospitals do and what people – policymakers, regulators, and workers – do about hospitals. For our purposes today, it's important to understand that dominant firms play a decisive role in setting employment standards not only within their own facilities, but in their industries more broadly, and indeed across the entire service sector. In Pittsburgh's labor market, hospitals are what economists call a price-maker—and, in this case, a "wage-maker."

Though neither of Pittsburgh's large hospital systems are transparent about the wages they pay, from BLS data and occasional public statements by hospital executives we estimate that the

[1] Employment in health services in the Pittsburgh metropolitan area in August 2015 was 163,700; total private sector employment was 1,075,800. See http://www.portal.state.pa.us/portal/server.pt?open=514&objID=1987969&mode=2.
[2] http://www.upmc.com/about/facts/pages/default.aspx

median wage for service workers in Pittsburgh hospitals is about $13.00/hour, or $27,000/year.[3]

To put this wage in economic context, the Economic Policy Institute calculates that a single childless adult in the Pittsburgh metro area needs just a bit *above* $13.04/hour to live a no-frills existence (no savings, no education, no travel outside of to and from work, all meals cooked at home and so on) without recourse to public assistance. This means that half of all hospital service workers in Pittsburgh do not bring home enough to meet this basic childless, never-get-ahead standard. At this wage, a family of two working adults and two children or a family of one working adult and one child are eligible for subsidized health care and child care.[4] And at the start rate of $11 said to prevail at the city hospitals of UPMC,[5] a family with a single parent and one child would also be eligible for food stamps.[6] If they have larger families, low-wage workers in Pittsburgh hospitals are in even greater need of public assistance.

Table 1: Basic Family Budgets vs. Poverty Thresholds for Pittsburgh, PA, Metro Area, 2014[7]

Family type	Single adult	2 adults, 2 children	1 adult, 1 child
Basic Budget, Annual ($)	27,120	64,692	46,176
Basic Budget, Hourly Per Adult ($)	13.04	15.55	22.20

Source. See footnote 7

The fact that hospital service workers, many of whom have quite responsible positions and post-secondary education, earn so little underscores the fact that Pittsburgh's labor markets are not truly competitive and that hospitals have some control over the wages they set. Pittsburgh's hospitals, in other words, use their size and dominant market position to hold workers back.

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[3] The average wage for "healthcare support' worker in the Pittsburgh metro area is $13.55 per hour (http://www.bls.gov/regions/mid-atlantic/news-release/occupationalemploymentandwages_pittsburgh.htm).

[4] Pennsylvania's Compass website at https://www.compass.state.pa.us/Compass.Web/Screening/DoIQualify#/Results; calculations assume that no one in the family has disabilities or is a veteran, that the adults in the household are married and are parents of the children, etc.

[5] http://www.post-gazette.com/local/city/2014/02/17/Religious-group-protests-against-UPMC-wages/stories/201402170070

[6] Compass website, op. cit.

[7] Basic family budgets are derived from the EPI Family Budget Calculator at http://www.epi.org/resources/budget/budget-factsheets/#/462; these were updated in August 2015 and are in 2014 dollars. Poverty guidelines for 2014 are from the US Department of Health and Human Services: http://aspe.hhs.gov/2014-poverty-guidelines

When they do, they depress service sector wages across-the-board. They also contribute to unemployment because they undercut the purchasing power of worker families in the region.

Since it's often taken for granted that wages are set by "the market" it is worth pausing to fully digest the contemporary economic reality that, in fact, firms with market power have significant autonomy over the wages they set. In economics, when a buyer of something is the only game in town, we speak of a monopsony. Like a monopolist (a single seller), a monopsonist has enough market power to not simply accept as given a "market wage." Twenty-five years ago, many mainstream economists (although not institutional economists and industrial relations scholars) took for granted that labor markets were competitive. Since then, there has been a sea change within the profession, prompted in part by what is called "the new economics of the minimum wage." It is now generally accepted that employers in low-wage labor markets have a degree of monopsony power. As a result of their size and the non-competitive (i.e., oligopolistic) nature of their own product market, the biggest hospital employers likely have the most monopsony power.[8] And these hospital employers use it to hold down wages to the detriment of the health of the region and its working families.

Many service workers who are employed by large, powerful hospitals in concentrated markets have few practical options if they wish to improve their wages and working conditions. A small number may be able to leave the industry and find a position that pays more. A few others may be able to move up from "starter jobs" to significantly higher-paid jobs, although the educational barriers to advancement, for example, to LPN or RN positions, are substantial. But for many service workers, their "starter job" may be their "finisher job" or close to it, with limited wage progression possible along any kind of career ladder.

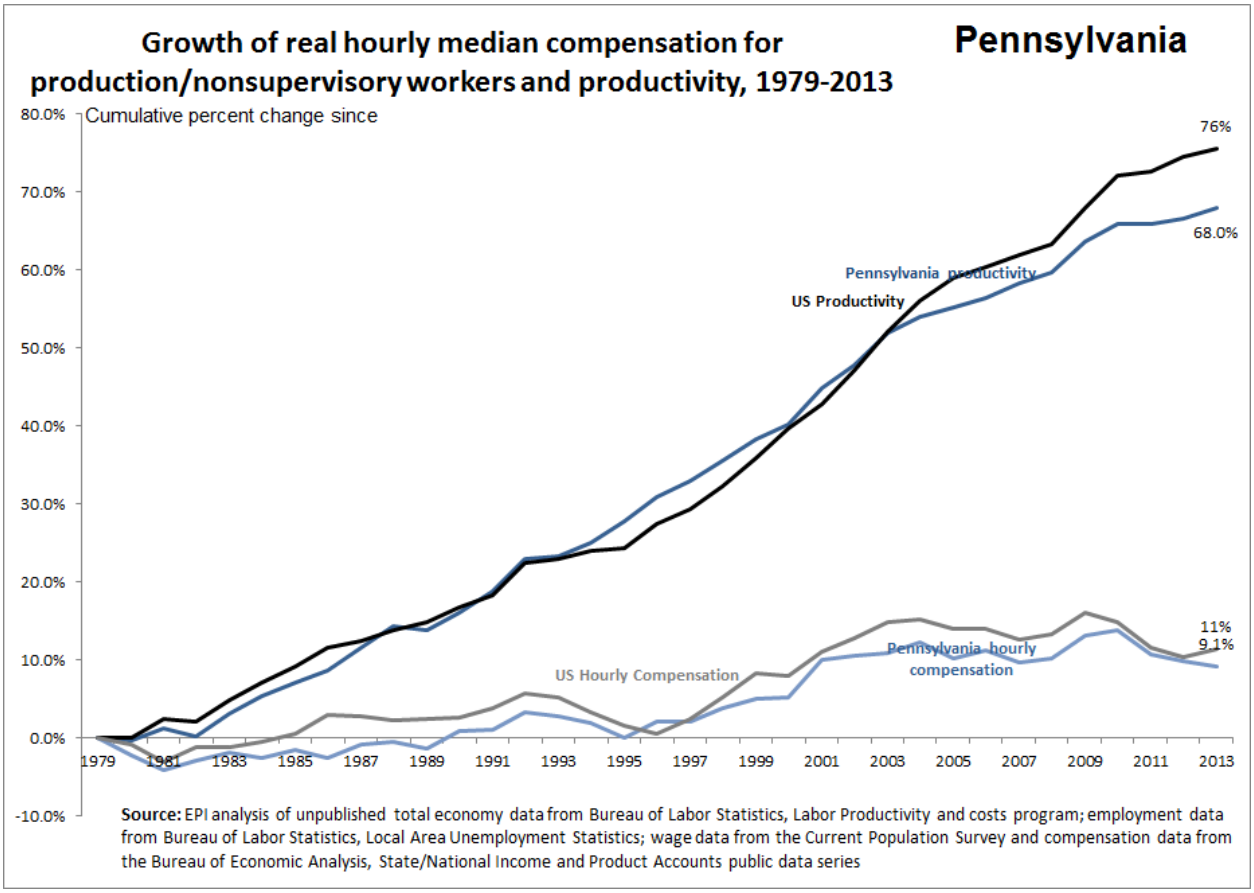
Another option – and the only practical option for vast numbers of service workers – is to improve working conditions through policies and institutions that create a better balance in the labor market and counteract employer's monopsony power. Policy and institutional changes, of course, are precisely what a previous generation of workers in Pittsburgh achieved when they

[8] One of the early classic discussions that recognized the fact that low-wage employers might have significant monopsony power is David Card and Alan B. Krueger, *Myth and Measurement: the New Economics of the Minimum Wage* (Princeton University Press: Princeton, New Jersey, 1995), see especially pp. 369-386.

joined Pennsylvania's manufacturing unions and by doing so, built Pittsburgh's middle class. The good jobs in the highly concentrated steel mills that powered Pittsburgh's economy in the last century didn't start out as good jobs. On the contrary, they were low-paying, dangerous jobs that generated outsized profits for owners and levels of inequality at the end of the 1920s greater than at any other time in American history – until now. That gaping inequality disappeared because workers – the grandfathers and grandmothers of many people in this room – stood up and organized, because the community supported them, and because elected officials promoted policies to reduce poverty and income inequality. In today's dollars, the start rate for the lowest-paid steelworker who entered the mill right off the street in 1970 was $17.00 per hour – a third more than the current hospital start rate.

As the Keystone Research Center documents in a recent national report, just about every state in the nation, including Pennsylvania, is experiencing extremely high levels of economic inequality – levels rivaling the inequality of the gilded age.[9] This inequality results from 35 years of policies that shift the balance of power in the job market to employers (e.g., a lower minimum wage, the declining influence of unions, economic deregulation and free trade agreements, immigrant policies that depress low-end wages). These policies have resulted in workers sharing in almost none of the gains in productivity growth in our economy – as the chart below shows.

[9]Estelle Sommeiller and Mark Price, *The Increasingly Unequal States of America*, Economic Analysis Research Network, online at *http://www.epi.org/publication/income-inequality-by-state-1917-to-2012/*. For a Pennsylvania-specific brief, see Mark Price, *Increasingly Unequal in Pennsylvania: Income Inequality 1917 to 2011*, Keystone Research Center, online at http://keystoneresearch.org/publications/research/UnequalStates.



A wage board – or wage committee – process that considers, as did the New York fast food wage board, what sector or occupation-specific wage minimum best serves the public interest of Pennsylvania, or in today's case, Pittsburgh, makes a vital contribution to the region's discussion about more people can be included in Pittsburgh's new prosperity. In our view, a minimum wage of at least $15 per hour for health care workers would have multiple benefits: it would reduce child poverty and lift more workers in health care into the middle class; it would set a standard for other sectors that achieves additional progress on reducing inequality; it would strengthen the economic recovery by putting more money in the pocket of working families. In addition, implemented intelligently such an increase could improve quality of care by reducing turnover among lower-wage health care employees and creating a context in which all workers can be incorporated into team efforts to improve the quality of care. Last, there is no reason to expect that such an increase would necessarily increase costs, including to taxpayers. Fewer workers would need to receive means-tested public benefits (e.g., Medicaid, food stamps/SNAP, subsidized child care). Within the health care sector, workers paid less than $15 per hour are a

small fraction of total costs, vastly outweighed by the cost of higher paid professionals, technology, and prescription drugs. Lastly, quality pays (or saves) – across industries but certainly in health care. Based on all these considerations, we recommend that City Council strongly endorse an increase in the minimum health care wage to $15 per hour and call on health care employers to provide plans to implement this goal.

Over the past decade, and with increased intensity in recent years, Pittsburgh's healthcare providers have engaged in ferocious vertical and horizontal integration to maximize their leverage in the market. The result for workers is a labor market that leaves service workers undervalued and underpaid, with no reason to expect that market forces will rescue them. Without lifting the wage floor in the region's dominant employer in its dominant service industry, Pittsburgh cannot rebuild its middle class. Thus the key question facing Pittsburgh and our nation today is whether workers, communities, and elected officials once again have the creativity and the conviction to build a new – in this case, 21st century – American middle class.