A NEW DAY IN THE NEIGHBORHOOD

How Pittsburgh’s new leaders can ensure good jobs, union rights, healthy neighborhoods, and a city for all

A SPECIAL REPORT OF PITTSBURGH UNITED
Executive Summary

Pittsburgh is a union town. This city is well known for its rich and deep legacy of manufacturing workers building power, fighting for living wages, and demanding a voice on the job. It is perhaps less well understood that Pittsburgh’s industrial unions are directly responsible for the birth and growth of our hospital industry. Pittsburgh’s scattered charity hospitals became today’s massive healthcare industry largely because Pittsburgh’s workers bargained health insurance into their contracts and fought to create government healthcare programs. Without these victories, there could be no UPMC.

When the steel industry drove the city’s economy, Pittsburgh’s middle class was stable and strong, built on a foundation of family sustaining union jobs. Now, our biggest employer is UPMC. Just as the steel industry set the economic tone in the last century, UPMC is setting the standard for jobs in Pittsburgh today, but with drastically different results.

Today, income inequality is as high as it’s been since the Great Depression, and the middle class is shrinking rather than growing. A phrase often heard around town in recent years is “a tale of two Pittsburghs.” For some, it’s considered the country’s most livable city. For others, living and working here is a health hazard.

Pittsburgh ranks last in the country for Black women in the categories of health outcomes, poverty and income, employment and education. The single largest social determinant of health is wages. And, nearly 7,000 Black families have been driven out of the city in the last ten years due to rising housing costs.

Experts agree that helping workers to form their unions is a key component of creating a livable city. It is also clear that honoring workers’ historic vision for a healthy and caring region will require a more fair and balanced relationship between decision-makers at UPMC and the community that it is meant to serve.

In this report, Pittsburgh United lays out clear, simple recommendations for fixing what ails Pittsburgh. UPMC must:

1. Allow workers to organize their union in UPMC facilities without interference.
2. Raise minimum pay for service workers to $20.00/hour immediately.
3. Eliminate medical debt for caregivers.
4. Create sustainable paths to safe staffing.
5. Reconfigure the Board of Directors to better balance representation from workers and community care advocates, and to reflect our city’s racial, gender and income diversity.

There is also a role for government to play, including:

1. Negotiate a robust community benefits agreement with UPMC.
2. Refine and update existing regulations and codes at the city, state and federal levels to enhance community accountability.
3. Regularly assess taxpayers’ subsidization of UPMC facilities.

In order to make Pittsburgh truly a city for all, UPMC needs to pay living wages and respect workers’ rights to form their union free from harassment and intimidation. Pittsburghers are tired of propping up an institution that pays poverty wages, keeps large swaths of the community sick, and refuses to work with us to meet community needs as the community defines them.

As new leaders take the helm at UPMC and in the mayor’s office, the time is right to ensure healthy wages, healthy workers, and a healthy Pittsburgh.

Why Update Our Report Now?

On February 20, 2013, Christoria Hughes, a dietary worker at UPMC Presbyterian, entered the USX Tower hoping to talk to UPMC executives about the hardships faced by thousands of hospital workers in Pittsburgh. On that day,
Hughes became the first worker in Pittsburgh to publicly call for $15/hour and a union for every service worker. She didn’t succeed in getting a meeting; indeed, she was arrested and escorted from the premises. But her action sparked an important city-wide conversation about the relationship between UPMC — Pittsburgh’s largest employer, landowner, healthcare provider and charity — and the people of our region.

In the same year Christoria and UPMC workers began their public fight for improvements for caregivers, Pittsburgh United published a report detailing public subsidization of the growing health system and calling for increased accountability to UPMC’s stakeholders - especially the community. Since 2013, the system has consolidated both horizontally and vertically to become a massive “global health enterprise,” Pittsburgh’s dominant anchor institution and the driver of our “eds and meds” economy. In 2020, UPMC’s hospitals, physician practices, insurance providers, nursing homes, homecare agencies and dozens of for-profit subsidiaries brought in more than $23 billion in revenue,2 making UPMC’s budget more than 40 times that of the city itself.3

Every day, workers bring their hearts, hands, brains, and backs to the work of caring. Taxpayers contribute in the form of tax subsidies as well as Medicare, Medicaid and veterans’ payments. As the system has grown, so too have these investments.

But despite more facilities, more insurance premiums, more labor and more subsidies, we are still unable to ensure area residents dignity or equity. In fact, as we watch health and wealth gaps widen, it seems hard to avoid the conclusion that our investments in UPMC are fueling problems such as poverty, occupational segregation, disparate health outcomes and residential “push out;” problems that prevent Pittsburgh from being a healthy and affordable place for those who call our city home.

With new leadership at UPMC and with a new mayor taking office next year, Pittsburgh United is called to take stock and refresh our recommendations for how UPMC and our city can work together to make Pittsburgh a more equitable and healthy place for all of us. In updating this report, we interviewed and consulted the testimony of hundreds of healthcare workers, the hardworking Pittsburghers who make caring for others their life’s work. We also consulted with area academics, labor and urban development experts and economists on measures of affordability and livability, and healthcare experts familiar with UPMC’s business model. All offered ideas for investing UPMC’s immense power and wealth, as well as the work and resources of our people, to improve outcomes for residents and workers alike.

Pittsburgh’s history is grounded in the labor organizing of manufacturing workers in the middle of the last century. It is well known that union organizing created a city in which, for the first time, large numbers of working families could achieve a decent if modest way of life, and was the basis for creating Pittsburgh’s working class neighborhoods. It is perhaps less well understood that Pittsburgh’s industrial unions are directly responsible for the birth and growth of our hospital industry. Pittsburgh’s scattered charity hospitals and institutions became today’s massive healthcare industry largely because Pittsburgh’s workers bargained health insurance into their contracts and fought to create government healthcare programs.4 Without these victories, there could be no UPMC.

After forty years of declining worker organization and declining standards for working families, experts agree that helping workers to form their unions is a key component of creating a livable city. It is also clear that honoring workers’ historic vision for a healthy and caring region will require a more fair and balanced relationship between decision-makers at UPMC and the community that it is meant to serve.
An Empire Built by Labor

When the steel companies substantially downsized their steelmaking operations in Pittsburgh in the 1980s, the region lost more than 100,000 manufacturing jobs, leaving a hollowed-out economy. This new reality was devastating to families and communities in the area, resulting in extreme hardship and uncertainty for many. Ironically, this economic catastrophe was itself to give rise to the region’s next big industry — healthcare.

In 1950, nearly half of the Pittsburgh region’s workforce was employed in manufacturing, mining, construction, rail, or trucking and warehousing — with metal production alone accounting for one-fifth of all employment. By 1960, industrial work had fallen to 30 percent of the regional labor market, beginning a trend that continued over the next decades.\(^5\) It’s important to note that the long-term downward trend in employment did not affect men and women, or white and Black people equally, as women and African-American men were laid off sooner and in larger relative numbers in any given downswing.\(^6\) Due to union protections, those who kept their jobs were generally older and the workforce aged noticeably over several decades: in 1950, 38 percent of steelworkers were aged over forty-five years; in 1980, more than half were.\(^7\)

In 1949, a pair of legal cases involving Steelworkers affirmed that health and other welfare benefits were mandatory subjects of bargaining. All industrial unions then began to bargain aggressively for robust health coverage for their members.\(^8\) By the end of the 1950s, steel industry contract negotiations alone accounted for 5 to 6 percent of nationwide Blue Cross coverage. In markets like Pittsburgh where steelworkers were concentrated, hospitals expanded and modernized to capture this new stream of insurance money, much of it paid to Highmark.\(^9\)

Generous, collectively bargained private-sector insurance coverage for industrial workers in turn drove up the cost of care as well as community expectations, giving rise to the political demand, supported by the country’s industrial unions, for the expansion of publicly-funded medical insurance for the poor and the elderly. Medicare and Medicaid, created in the mid-60s, were in this sense “invented” by workers who were themselves insured and politically powerful, but were also rapidly aging, and increasingly economically unstable thanks to the advance of deindustrialization.

Thus as manufacturing employment collapsed, much of the regional economy followed suit. In contrast, hospitals, nursing homes, and home care agencies expanded rapidly in the last three decades of the twentieth century.\(^10\) And although recent decades have witnessed the shredding of the social safety net and programs that sustain economic security, our outlays for healthcare continue to grow. Utilization of health services spiked rapidly throughout the 1970s, with active steelworkers, retirees, and their dependents leading the trend. By 1979, Pittsburgh generated an average of 1,614 annual hospital patient-days per 1,000 in the population, a rate 23 percent higher than the national average.\(^11\) Through the 1970s, a wave of hospital capacity expansion, financed with cheap municipal debt, both accommodated and further stimulated rising demand. Allegheny County established a public authority to help capital-hungry health institutions borrow on tax-free municipal bond markets. And with taxpayers and insurance subscribers guaranteeing reimbursement for healthcare services, institutions had every reason to borrow and build.\(^12\) Policymakers recognized the threat of hospital overcapacity, but hospital upgrades were generally too popular to resist, as they offered care and employment to a population whose needs were growing and provided economic investment in a region struggling with disinvestment and depopulation.

This countercyclical growth of the healthcare industry continued even when the mills shut down entirely. Addiction, malnutrition, housing insecurity, heart disease, intimate partner
violence, stress, and depression proliferated as an overtaxed social safety net, stretched to breaking by federal and state austerity and local fiscal shortfalls, proved incapable of addressing growing need. In this economic and social environment, only prisons and the healthcare system were able to expand in tandem with the crisis. Medicaid expanded as more people became poor and thus qualified for benefits, and Medicare covered a growing portion of the aging population. The private benefits negotiated in collective bargaining also proved a source of income for devastated communities: steelworkers’ retiree benefits injected cash into the mill towns of the Monongahela Valley in the form of health-care payments to places like Braddock Hospital.

Countercyclical hospital expansion also depended on a ready reservoir of cheap labor. Women and people of color, pushed to the margins of the economy in the steel era, now had even more urgent need of work to compensate for the steep economic decline. Overwhelmingly, hospitals hired women into caregiving and support roles. Women were available for employment because their earnings were needed to lessen the impact of the vanishing “family wage” once provided by men’s full-time union jobs. Of course, women’s entry into the labor market occurred unevenly along racial lines; African-American women almost always worked, but they began moving from domestic work into institutionalized care in the late 1960s. Over the next decade, white women needing to compensate for lost industrial wages joined them, often with the opportunity to enter higher up on the occupational ladder. In general, however, all women were “prequalified” for caring jobs by their experience in the patriarchal working-class family, where they had been “trained” to care for others for much of their lives.

Working people — in their strength as the force behind widespread health insurance, in their pain as displaced manufacturing workers, and as the workforce for the new meds economy — created today’s healthcare industry. But that industry has often failed to meet their needs. Reacting to increasing healthcare outlays, lawmakers began to seek ways to reduce and rationalize payments to hospitals. In 1983, Congress switched Medicare from a cost-plus reimbursement system to a “prospective payment system” that married fixed reimbursement rates to specific diagnoses, encouraging hospitals to specialize, economize, and compete — and laying the basis for managed care. The effect of this change was to place a premium on intensive medical intervention and to devalue the kinds of everyday low-intensity care that the population had come to depend on from its hospitals. UPMC understood the opportunity, invested in technology and new capacity, and developed specialties in expensive, complex treatments that they sold on national and even global markets. Smaller community hospitals, formerly the backbone of the industrial workers’ healthcare system, began to fail as the kind of care they provided became unprofitable. UPMC bought many of these community hospitals only to close or downsize them. Braddock, Aliquippa, and other regional hospitals built by and for workers during the last century have been shuttered like the mills around them. Others, like UPMC Bedford and UPMC Jameson, have closed essential departments as a result of two decades of hospital consolidation.

And while hospital giants like UPMC may owe their existence to strong industrial unions, UPMC has resisted worker organization in its own facilities. At UPMC, workers who attempt to form their union are routinely met with hostility and threats rather than as partners. UPMC has also offloaded and outsourced jobs associated with non-intensive and unremunerative care, often to its own outpatient or long term care facilities. This “rationalization” has increased the internal stratification of the healthcare workforce along race and gender lines and led to the elimination of a variety of family-sustaining jobs, such as medical transcriptionist, which at UPMC went from being a high wage profession employing mostly women to an outsourced piece rate “gig” paying wages that were often illegally low. Workers experience such “efficiency” measures as wage depression and deskilling and also as understaffing, speedup, and so-called cross-training, where
workers are pushed to take on tasks they are untrained for. Unsurprisingly, the care economy has accounted for an absolute majority of new low-income jobs over the last several decades. This then is the paradox of UPMC: as our society has become more distressed, unequal and more insecure, we have become more dependent on an entity that drives inequality and insecurity. It is this dynamic that we must change.

**Caregiving as Work**

Every day, UPMC’s 92,000 employees bring their time, skill and commitment to the work of care. About 53,000 of them work and live in our region, where healthcare and social assistance employment accounts for more than 21 percent of the region’s workforce, more than double the percentage of the total workforce held by any other sector. Approximately 50,000 full-time equivalent employees work in hospitals in the Pittsburgh area; of that 50,000, roughly 33,000 work in the eight UPMC hospitals.

Non-managerial hospital workers include nurses and nursing assistants, radiology and laboratory technicians, food service workers, secretaries, environmental service technicians, and a host of other professionals who care for patients or play support roles. Service workers, who are sometimes and wrongly described as unskilled, are the single largest group of people working in hospitals, performing a variety of functions related to patient care, including assisting with activities of daily living, cleaning, stocking supplies and equipment, cooking, processing specimens, completing and managing drug orders, sterilizing surgical instruments, keeping patient records, and transporting patients, among other critical tasks.

Healthcare jobs are physically, emotionally and mentally demanding. Workers juggle simultaneous demands in a high-stress, fast-paced environment where, as workers well know, lives are literally hanging in the balance. For many workers, the ability to make a difference is part of what attracted them to the field and they are

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**Summer Viscusii**

I am a Student Behavioral Associate at Western Psychiatric Hospital, UPMC’s in-patient mental health facility. I work on many floors of the hospital, so I’ve seen a lot of what happens there. On a typical day, I might work with autistic patients and people with developmental disabilities; I feed people, clean up after them and help them bathe, and restrain people when they are a risk to themselves or others. I’ve been there just over a year.

When I started this job, I was excited to be working in patient care and I thought the pay was great because it was more than I made working at a gas station. It’s true that the pay at Western Psych is more than minimum wage, but it’s not nearly enough for the job and the way UPMC treats us.

I knew this job was going to be dangerous, but it doesn’t have to be as dangerous as it is at Western Psych. We work understaffed a lot of the time, meaning there aren’t other people around to help you if you’re in trouble. I’m always hyper-vigilant, I never really “come down” anymore. Sometimes I’m at home and the microwave beeps and it sounds like a body button alarm and I snap into emergency mode.

There are so many jobs at UPMC that are the hardest jobs, and they’re the ones you never hear about. Hard labor keeps hospitals functioning. My job is hard, but the people who collect linens, the janitors, these are all the hardest jobs, especially in a pandemic. And we do not feel valued by UPMC.

I found my passion working at Western Psych, and I love my work. I’m going to keep giving my patients the best care possible, and I’m going to work to hold UPMC accountable to taking care of its workers.
rightly proud of their ability to perform complex tasks and solve problems on the go, as they ensure that patients receive the best care possible. But responsibility also contributes to the enormous stress that healthcare workers experience and talk about every day.

Chronic short-staffing dramatically compounds the challenges of caregiving. As noted earlier, staff reductions, speed up and “flexible assignments” are now as common in hospitals as in factory work. Indeed, because labor represents such a great fraction of healthcare costs, squeezing more out of fewer workers is an important part of how hospitals generate profits. But these practices, which leave caregivers to intervene in situations without enough hands, or “float” staff to units where they have no experience, increase danger for patients and workers alike. Staffing shortages and inappropriate assignments contribute to startling rates of turnover, burnout and poor mental health, all exacerbated by the COVID-19 pandemic. A recent study conducted by researchers at the University of Pittsburgh revealed that over one quarter of all healthcare workers screen positive for depression, anxiety and/or post-traumatic stress syndrome. One in 10 healthcare workers reports suicidal ideation.

Today, hospitals have perhaps reached a tipping point where “normal” understaffing has escalated to reach crisis proportions. With literally thousands of vacancies for caregivers, UPMC is now turning to staffing agencies, sign-on bonuses and retention contracts that make care more costly without addressing the underlying causes of turnover or burnout.

Wages, Benefits and “Livability”

As the largest employer in Pittsburgh, UPMC’s decisions about pay and benefits affect not only tens of thousands of its own employees but also influence the whole of the service sector labor market. Though some UPMC workers are paid living wages for the work they do, the largest category of workers are paid considerably less than what is needed to cover basic needs in Pittsburgh. This contributes to the concentration of poverty and poor health outcomes in neighborhoods where service workers live.

Today, most UPMC workers in the city of Pittsburgh have a starting rate of $15/hour or about $31,000 a year. This fact is somewhat remarkable given that as recently as 2014, UPMC claimed that rate was impossible. But in 2016, as workers prepared to strike and in the face of increasing community pressure, UPMC changed course and pledged to raise starting wages at its Pittsburgh facilities to $15/hour by 2021. But $15 was not enough in 2016 and is certainly not enough today. In 2013, when Christoria Hughes first called for a floor of $15/hour, the estimated median wage for service workers at UPMC was $12.18, meaning a jump to $15 represented a substantial raise for the majority of workers. But by 2021, inflation has eroded the value of the increase considerably and has indeed returned the average worker to the 2016 starting line; to have the purchasing power of $15 in 2016 dollars, a worker today would need to start at $17.28.

Today, $15/hour certainly lifts a worker with no dependents above the official poverty line. But experts tell us that the method for calculating federal poverty thresholds, developed more than half a century ago, is no longer a reliable measure of the adequacy of workers’ income. For that reason, researchers have developed newer “shopping cart” methods to measure the actual cost of living in cities across the United States. The Economic Policy Institute (EPI) updates and publishes these figures annually in order to determine “the income families need in order to attain a secure yet modest living standard where they live by estimating community-specific costs of housing, food, child care, transportation, health care, other necessities and taxes.” We should note that many items that we would consider “necessities” for a “se-
cure and modest living” don’t find their way into the shopping cart used to establish EPI’s family budgets. For instance, living wages calculated in this way make no provision for savings, for debt maintenance, for post-secondary education, for “luxuries” like transportation to places other than work, for entertainment, or even for internet service, meaning that people who live within these budgets are not well-positioned to participate fully in society or weather minor financial crises, let alone develop equity or get ahead.\textsuperscript{37}

The table below shows the minimum income a family in Pittsburgh would need in order to afford a basic family budget, updated to March 2018.\textsuperscript{38} For reference, the table also includes the official U.S. poverty threshold for each family type.\textsuperscript{39} According to the U.S. Census Bureau, approximately 20.5\% of people in Pittsburgh lived in households below the federal poverty threshold between 2015 and 2019,\textsuperscript{40} compared to about 12\% statewide.\textsuperscript{41} Naturally, the percentage of families whose income does not meet EPI’s higher family budget standard is much larger. At hospital service workers’ median 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 in the state of Pennsylvania.\textsuperscript{42}

As the single biggest social determinant of health,\textsuperscript{43} workers’ income has a direct impact on their well-being. Low wages find direct and indirect expression in poor health outcomes. Given the gap between hospital service worker wages and the income necessary to meet basic needs, it’s unsurprising that many hospital workers report hardships in their lives.\textsuperscript{44} The Pittsburgh Wage Study, an ongoing investigation of the impact of both low wages and wage increases conducted by researchers at the University of Pittsburgh and supported by the Heinz Endowments, focuses specifically on hospital workers and catalogues the hardships that workers experience as a result of inadequate wages. These include lack of health care, inability to cover bills for basics like electricity, heat, car insurance, medication and groceries, lack of transportation, inability to provide adequate housing or to afford housing in safe and stable neighborhoods, inadequate or unhealthy food, extreme exhaustion and stress, inability to save for their own or their children’s education, inability to afford clothing for their children, and dependence on public assistance, among other hardships. The study also indicates the difficult and sometimes demeaning strategies workers use to compensate for inadequate pay, strategies such as delaying marriage, becoming indebted to friends and relatives, juggling bills, having utilities shut off or just going hungry.\textsuperscript{45}

The direct relationship between income and health outcomes was also documented by Professor Ray Engel from the University of Pittsburgh School of Social Work in his testimony to the Pittsburgh Wage Review Committee. He shared research by Hilary Seligman and her colleagues at the University of California San

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<tr>
<th>Family Type</th>
<th>EPI Family Budget</th>
<th>2021 Federal PovertyThreshold</th>
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<tr>
<td></td>
<td>Hourly Wage</td>
<td>Annual Income</td>
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<td>2 Adults, 2 Children</td>
<td>$37.87</td>
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Francisco showing that among low income individuals, in the last four days of the month before workers’ receive their next paycheck, there is a 27% increase in low income individuals’ hospital visits for low blood sugar. There was no similar increase among higher income individuals.46

Benefits are also often inadequate. UPMC worker Bernadine Glover, one of roughly 200 workers who offered testimony to Pittsburgh’s Wage Review Committee convened by Pittsburgh’s City Council in 2015, made the link between UPMC insurance and her own health outcomes: “The health insurance isn’t good for the employees. You have to pay so much out of pocket when you go to the doctor’s office. Then you get bills. I pay $190 a month in healthcare to UPMC. For all the prescriptions I need, I pay another $200 a month ... Right now I owe the hospital thousands of dollars. I don’t have the money set aside to pay these bills. I don’t have much set aside at all. I’m supposed to go to various doctors’ appointments for my health issues. In 2013, I had a kidney removed. I skip follow up appointments because I can’t afford the copays to see the doctor. I just hope everything is okay until I can afford the next visit.”47

UPMC does not report data about the medical indebtedness of its workforce, but in 2019, UPMC workers undertook their own self-study to learn how many workers were also in debt to their employer. They learned that of the employees who responded, over 60 percent owed money to UPMC.48 For Senator Lindsey Williams, who attended a press conference at which workers presented their Explanation of Benefits (EOBs) and collection notices to Attorney General Josh Shapiro, the idea of UPMC workers owing UPMC brought up memories of the company store.49 Certainly UPMC controls every element of the medical debt equation: as provider, it sets the cost of care; as insurer, it determines the provider network and determines coverage and copays; as employer, it controls wages and dictates what insurance will be offered. Absent the ability to bargain over wages and benefits, workers must take UPMC insurance, must use UPMC facilities, and must accept what UPMC wishes to pay them. In other words, UPMC is solely responsible for workers’ debts.

Raising Expectations: It’s Time for $20

The Pitt Study provided an important snapshot of the hardships endured by hospital workers. But it has also followed workers longitudinally to assess the impact of improvements in wages and benefits. In the most recent update to their findings, Pitt researchers shared conclusions drawn from their study of workers at Allegheny General Hospital, where in 2015 workers formed their union and have since bargained two contracts. This has allowed some workers to move beyond $20/hour over time.50 Workers earning above $20/hour had much lower levels of food insecurity, housing hardships, and essential expense hardships than those earning below $20/hour, suggesting that $20/hour is a better goal than $15/hour to alleviate material hardships among workers. They also learned more about workers unable to afford medical care, finding that one-third of those earning below $20/hour but only one-fifth of those earning above $20/hour report medical debt, though disturbing proportions of both groups have delayed or postponed needed medical treatment because of cost. Finally, they discovered that 80% of workers earning below $20/hour – and still over half of workers earning above $20/hour – are living paycheck to paycheck, without savings or realistic plans for retirement.51

Housing and Safe Neighborhoods

Despite Pittsburgh’s reputation as an affordable city, the shortage of affordable housing for people below the city’s median income continues to grow.52 Housing insecurity is both a cause and an effect of other kinds of hardship. The same forms of privation and instability that lead to skipped doctors appointments, shut-off phones, and trips to the foodbank can lead to
missed rent or mortgage payments and thus to eviction, shelter poverty, or even foreclosure.

This map, taken from the City’s Wage Committee Report, reflects the dynamics as they affect low wage hospital workers.\(^5\)

In the wards with the highest concentrations of low wage hospital workers, workers make up nearly 5% of the total workforce, meaning that nearly 1 in every 20 working adults is a service worker in a Pittsburgh hospital. In other wards, service workers are relatively few and far between, comprising less than 1 percent of all workers. It is also clear that wards with high hospital service worker density are wards with high concentrations of poverty, as can be seen by comparing these geographies to the areas of the city eligible for Community Development Block Grants.\(^5\)

Census data also reveals that a high concentration of hospital workers correlates closely with areas of the city where many African American Pittsburghers reside.\(^5\) But the housing crisis can also lead to workers leaving, or being displaced from the city altogether.

Carl Redwood, a local housing expert and Co-Chair of Pittsburgh United, provided insight into Pittsburgh’s “push out problem,” which he described as “most severe for families and households who have very low and extremely low incomes.” Redwood notes that in the past 20 years, Pittsburgh has lost 20,000 Black people in the city and gained 35,000 in the suburbs and attributes this population change to rising rents and suppressed wages at the city’s largest employers.\(^5\)

**Children**

Among students attending Pittsburgh Public Schools, approximately 63 percent are classi-
fied as low income using federal standards. Decades of research and data show that family income is the primary predictor of a child’s educational success and indicate the far-reaching effects of low wages on a child’s development, including not only the ability to go to museums and other educational trips, afford books, clothes and shoes and eat nutritious food at home but also educational achievement and future success.

A frequently-cited 2012 study by Sean F. Reardon, a Stanford University sociologist, found that the gap in standardized test scores between wealthy and low-income students has grown by approximately 40 percent since the 1960s. Dr. Reardon explained to the New York Times: “We have moved from a society in the 1950s and 1960s, in which race was more consequential than family income, to one today in which family income appears more determinative of educational success than race.” But as we discuss below, in Pittsburgh, the connection between race and low income jobs is stronger than in almost any other city in the country.

A landmark study by Columbia University and Children’s Hospital Los Angeles published earlier this year found that children’s brain development is linked to family income. The study found that the brains of children in families with incomes of less than $25,000 a year had smaller cerebral cortex surface areas than those whose family annual incomes were $150,000 or more.

This research finds resonance in the issues and concerns raised by many workers who testified on the effect of low wages not only on their lives, but also on the lives of Pittsburgh’s younger generations. C.J. Patterson has worked at UPMC Presbyterian for roughly 20 years. He holds a second job in a local restaurant and is raising a grandchild in Pittsburgh. He notes that it is difficult to preach the gospel of “work hard and get ahead” when that’s not what kids see:

“I started in 1999 as a temp and worked my way up to the GI Lab. Like a lot of people I know I work extra hours to be able to support my family. Sometimes our lights have been shut off so I applied to United Way to help with the bills. I want to be able to tell my children and the kids in my neighborhood that they should get a job and work hard. I hate to drive down Frankstown Ave and see them all out there getting into trouble. But they see their parents giving their lives to these hospitals and still barely making it.”

Hospital Work for Women and People of Color

UPMC’s non-managerial workforce is disproportionately made up of women and African-American workers with less well paid jobs even more disproportionately held by people of color. Gendered and racialized patterns of occupational segregation result in income disparities which in turn mutate into health and wealth disparities.

Low wages for hospital service workers contribute to significant rates of poverty in Pittsburgh’s African-American community. Pittsburgh has the fourth highest rate of poverty among African-Americans out of all major U.S. metropolitan areas; and median earnings for African-Americans in our city are fifth and sixth lowest in the country for men and women, respectively.

A dominant factor contributing to these racial disparities is the type of jobs African-American Pittsburghers have.

Pittsburgh has the highest rate of African-Americans working in service occupations of any major urban area in the United States. According to the U.S. Census Bureau, only 23 percent of African-Americans in Pittsburgh work in management, business, science and arts occupations, the second lowest percentage among the top 40 Census regions. By contrast, 34 percent of African-Americans in Pittsburgh work in service occupations, the highest percentage among major Census regions. The concentration of Black women in low wage service jobs helps account for the fact that they earn 54 cents to every dollar earned by a white man and helps us to un-
stand why Black women and children are more likely to live in poverty in Pittsburgh than most in comparable cities.

With so many in Pittsburgh’s African-American community living at or near poverty, it is not surprising that home ownership among African-Americans in the city is approximately half that of non-Hispanic white residents (33.8% vs. 59.4%). Nearly 80 percent white Pittsburgh residents rated their neighborhood as a good, very good, or excellent place to live, while only 56.8 percent of black residents in the same survey rated their neighborhoods highly. Issues of limited transportation and poor health outcomes further illustrate the impact of low incomes and depressed communities on people of color in Pittsburgh. For example, U.S. Census data show that more than 35 percent of African-American workers in the City of Pittsburgh rely on public transportation to get to work with 41% of African-American households in the City reporting no access to any private vehicle.

In Pittsburgh communities, Black residents experience substantially higher death rates than white residents. The mortality rate for infants born to African American mothers in Allegheny County was 13 per 1000 in 2018, nearly six times the rate for whites and 30 percent higher than the already high national average for African-Americans. Black adult mortality rates are not only higher than they are for white Pittsburghers: they are higher than those of Black adults in 98 percent of similar American cities.

While health outcomes experts at UPMC rightly connect persistent health disparities to important differences in how Black people are diagnosed and treated, they are generally less attuned to the link between health disparities and working conditions — the occupational segregation and hardship created by UPMC as an employer. It is perhaps understandable that providers are attracted to interventions that are aimed at specific “at risk” populations and that focus on the improved provision of care. These interventions are welcome, but workers are also experts and typically identify additional strategies that involve not just better hospital care but also better distributions of resources and power. As Leslie Poston, a UPMC service worker with debt to her employer relates, “When I was diagnosed with early stage breast cancer, honest to God I almost didn’t go to the doctor when I found the lump. I just kept thinking about that $40 specialty copay that I didn’t have. Here’s what else I found out: I learned that black women have a lower chance of getting breast cancer than white women but white women are significantly more likely to survive. The Susan G. Komen Foundation says that is because of low income and access to follow-up healthcare.”

### Monopsony Power and the Need for Unions

In the labor markets described by classical economics textbooks, employers compete for workers and workers compete for good jobs, with the result that market rates are the right rates for the work being done. In the real world, the situation can be quite different. Many economists now accept that the labor market for service workers is broken. That’s because in an economy where high levels of unemployment are acceptable, any employer willing to accept high rates of turnover experiences little pressure to raise rates of pay in order to attract a workforce.

In Pittsburgh, the general dysfunction of labor markets is compounded by a specific employer, UPMC, that has acquired what economists call monopsony power – a buyer’s ability to manipulate their costs by reducing or eliminating workers’ options. UPMC’s consolidation is at the heart of its monopsony power. Twenty years ago, hospital workers dissatisfied with their situation at one hospital could look to many independent hospitals for a better deal. Today, to leave a UPMC hospital means leaving a network of hundreds of clinical locations where you can no longer be hired. For some workers, this situation is codified in contracts with non-compete clauses. UPMC doctors who quit or are terminated
report that they cannot work in Allegheny County for a year. But workers without non-compete clauses have also built their lives around delivering hospital care, by locating along a bus route that passes “their” hospital, by investing in their own training as caregivers, or, as is increasingly common, agreeing to a contract that ties performance bonuses to tenure.

Stephen Herzenberg, director of Keystone Research Center, testified before the City of Pittsburgh Wage Committee about the influence of UPMC wages in Pittsburgh on non-hospital service occupations and on the labor market in surrounding areas. Herzenberg notes, “In Pittsburgh’s labor market, hospitals are what economists call a price-maker – and, in this case, a ‘wage-maker.’”

Representatives of the hospitality industries are well aware of the impact of hospital wages and hospitals’ wage-setting power on workers in their fields. Mackenzie Smith, formerly of UNITE HERE, bargained contracts for service workers in Pittsburgh’s growing hospitality sector. Her perspective is revealing: “Pittsburgh hotel service workers cannot get the same deal they get with the same hotel companies in other cities because the prevailing conditions for service work in Pittsburgh is so low, due to the wages and conditions in Pittsburgh hospitals. At the bargaining table, we were told the hospitals are peer institutions for the hotels and casinos. They are bringing down the entire labor market.”

The effect of UPMC’s low wages extends even to the steel industry. In 1968, when real wages for so-called unskilled workers in the United States were at their height, a young person with no experience entering a Pittsburgh steel mill had a start rate of $2.65, a wage that today has the purchasing power of $21.22. But according to Kevin Cunningham, a steelworker at the Edgar Thompson Works, when the dominant employer starts people at subliving wages, then a ripple effect is felt through the whole economy. “Steel workers struggled for decades to make steel mill jobs safe, middle class, family sustaining jobs... Now, however, the steel companies have been emboldened by low wages in the service sector. When steelworkers go to bargain contracts with their employers, employers are fighting to push back wages, benefits and protections – the progress of decades is at risk.”

These facts argue strongly for the need for unions at UPMC. In a functional and competitive labor market, employees dissatisfied with their situation have the option to leave — what economists call “exit.” The threat of exit is what pushes employers to make improvements in wages, benefits, and other working conditions. Dysfunctional monopsonistic markets demand another solution — what economists call “voice.” Voice means empowering people with few market options to make improvements directly at the job they are on. Pittsburgh’s high level of economic inequality is rooted in the fact that the eds and meds economy is largely not unionized. Consequently, workers have not shared in the gains in economic productivity. The correlation between unionization and inequality is clear in the last century of data: in the middle of the 20th century, as union membership rose and remained high, lower wage workers earned a larger share of total income. However, in recent years this trend has reversed, with union membership falling and the share of income going to the top 10 percent increasing. The correlation between unionization and inequality reflects the causal impact of unionization on wages for workers at the bottom of the income distribution.

Unionization accounts for the fact that a housekeeper at a UPMC hospital earns $15 and has no retirement plan, whereas a unionized janitor cleaning UPMC downtown offices earns $20 and has a pension.

A report by the National Bureau of Economic Research finds that the children of union parents have higher incomes than the children of otherwise comparable non-union parents, especially when parents work in so-called unskilled occupations. The report also found that children raised
As union membership has fallen, the top 10 percent have been getting a larger share of income

Union membership and share of income going to the top 10%, 1917–2014


Democratic Policy Committee, Christoria Hughes pointed to the generational impact of UPMC’s low wages, comparing her pay to the pay of UPMC’s CEO not as a ratio but as history. “If a UPMC worker started their job at today’s wages right after the Civil War and worked straight through to the present, they would still have a century to go before they made what Jeffrey Romoff made last year.”

Unions are a particularly important strategy for non-white households. According to a recent study from the Center for American Progress, unions play a key role in redressing wealth gaps for everyone but tend to provide larger increases for Black and Hispanic households. The report

in communities with higher union density have higher average incomes relative to their parents when compared to children raised in communities with lower union density. Researchers have found union density to be one of the strongest predictors of occupational mobility even after controlling for variables such as race, types of industries, and inequality.

But perhaps most fundamentally, unions are a mechanism for improving workers’ lives over time. History is a significant factor in family and community improvement. Parents with retirement plans are less burden on their children, enabling children to move ahead. Houses are passed down as inheritance. In her testimony before the

Economic Policy Institute

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finds that:

- The median union household has more than twice the wealth of the median nonunion household.
- Black households with a union member have median wealth that is more than three times the median wealth of nonunion Black households.
- Hispanic households with a union member have median wealth that is more than five times the median wealth of nonunion Hispanic households.
- White households with a union member have nearly two times the median wealth of nonunion white households.

Despite the clear benefits of unions for workers, UPMC management has strongly resisted workers’ efforts to organize. After a trial concerning some of UPMC’s chronic labor law violations, Administrative Law Judge Mark Carissimi found that UPMC had engaged in “widespread and egregious” acts of intimidation, surveillance, harassment and discrimination and illegal firing. UPMC also exploited the Trump Labor Board to impede organizing by denying union organizers, and only union organizers, access to public hospital spaces such as cafeterias. UPMC’s monopolistic ability to constrain exit, coupled with its determination to crush voice, contributes to a widespread culture of futility and fear throughout UPMC facilities.

Geoff Webster, an expert in healthcare transformation and a founding partner and principal at Pittsburgh’s Value Capture, submitted this assessment to the Wage Committee: “Great organizations have several things in common. They deeply respect their workers, they listen to their workforce, their workforces are professionally safe to call out problems and highlight weaknesses as a basis for learning, and they show their respect by paying a wage that is not the least that the market will bear and indicates that the frontline worker is not expendable but is someone whose experience and development are worth investing in. Unfortunately, the Pittsburgh region, despite tens of thousands of exceptional healthcare workers striving every day to care for those who need healing, is trapped in a dark ages of leadership and management.”

Community Health Means Community Power

As a corporate entity, UPMC is classified as a private not-for-profit, governed by an appointed Board. But the Pennsylvania Constitution — and common sense — recognize that healthcare charities are also importantly public assets and must therefore be accountable to the communities they serve.

The public’s investment in UPMC is substantial. Medicare accounts for 48% percent of UPMC’s total patient revenue and Medicaid for another 17% percent. Together, these programs accounted for more than half (65%) of the $9.2 billion in patient revenue received by UPMC’s hospitals and other providers in 2020 and more than a quarter of UPMC’s $23 billion in total 2020 revenue.

UPMC also benefits from a variety of tax exemptions, including federal and state corporate income taxes, state and local sales taxes on certain goods, local property taxes, and the city payroll preparation tax. UPMC also pays reduced interest rates when it issues tax-exempt bonds. Pittsburgh United’s earlier report estimated that the ability to issue tax-exempt bonds saved UPMC at least $31 million. The same report also found that if UPMC were no longer tax-exempt, it would owe approximately $40 million in property taxes every year for the property it owns in Allegheny County alone. Altogether, the report estimated, exemptions given to UPMC alone amounted to more than $200 million in avoided taxes.

Elected officials and taxpayers alike lack a clear understanding of the exact value of UPMC’s tax subsidies. When the City of Pittsburgh sued UPMC in 2013 to challenge its tax exempt status,
it asked that UPMC be required to pay Pittsburgh’s payroll preparation tax. At that time, the City and its lawyers did not estimate the amount of payroll tax UPMC should be paying, only stating that UPMC was not paying “millions of dollars of payroll taxes based on billions of dollars of payroll expenses.” More recently, city officials who were contacted by the authors of this report shared that they were not able to estimate the value of UPMC’s payroll tax exemption, citing the complexity of UPMC’s corporate structure. This highlights not only the scope of the benefit UPMC receives in the form of tax exemptions but a profound lack of transparency and the need for more oversight. Public officials and citizens alike should be able to quantify the community’s tax subsidies to UPMC.

UPMC regularly claims that high levels of provider integration and consolidation pay dividends in the form of better health. But as healthcare spending grows as a fraction of GDP, many experts have noted the paradox of greater healthcare investment coupled with flat or declining population health outcomes. Most analysts agree that the high costs of medical care are related to high prices, ranging from drugs to doctors to administration. There is also a broad consensus that poor population health outcomes are associated with wages, nutrition, housing, education, and other social determinants of health, as well as the relative scarcity of non-intensive interventions and health maintenance services such as primary care, dentistry, and mental health support.

Economists like Marty Gaynor have refuted the idea that hospital consolidation improves healthcare quality, finding that it largely just increases costs and prices. County-level data compiled by the University of Pittsburgh Graduate School of Public Health suggest that hospital consolidation may actually lead to worse health outcomes. Over the decades of UPMC’s consolidation, Allegheny County’s health outcomes have declined relative to our 43 geographic peers. These data also show that unlike our peer counties, disparities between white and Black Pittsburghers have widened over the years of UPMC merger and acquisition.

In 2018 and 2019, as UPMC prepared to completely sever its relationships with hundreds of thousands of area seniors and patients carry-
ing Highmark insurance, community criticism of UPMC’s behavior as a healthcare charity came under unusually intense scrutiny. Pittsburgh’s Planning Commission unexpectedly recommended that UPMC enter into a community benefits agreement as part of its plan to expand the UPMC Mercy Hospital campus. Representatives of many advocacy groups, including Pittsburgh United, canvassed the Uptown neighborhood to hear neighbors’ concerns and then gathered to outline a community benefits agreement, or CBA, able to address those concerns as well as the needs of patients, workers, and residents living outside the neighborhood but affected by the project.

Initially, Pittsburgh City Council indicated its support for a robust CBA and at a hearing remarkable for its attendance and length, listened while more than a hundred residents, experts and elected officials spoke in support of the expansion and also in support of a CBA that would improve community health, both by providing more and better access to direct health services in line with UPMC’s own Community Health Needs Assessment and by addressing some of the most critical social determinants of health — on-the-job standards for healthcare workers, a commitment to run the facility using low-cost clean energy, and contributions to Pittsburgh’s affordable housing initiatives. Council voted to postpone approval of UPMC’s plan while it used the summer and early fall to work with UPMC and community members to hammer out an agreement.

UPMC’s reaction to what it perceived as illegitimate delay was swift and forceful. In emails between UPMC executives and city officials, UPMC’s CEO Jeff Romoff was described as “at the boiling point” while its Chief Counsel, Tom McGough, urged the Peduto Administration and Councilman Daniel Lavelle to ignore what he called a “motley assortment of activist groups” and approve UPMC’s plan immediately or face the possible closure of Mercy altogether. In the end, UPMC wrote its own “community agreement,” one that City Council, under pressure from the Mayor, voted to approve. The agreement involved no

Summary
Allegheny County Age Adjusted Mortality Rate Rank (of 43 large USA counties)
By Race and Sex

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Beth McCracken  
UPMC CANCER PATIENT

In 2013, I began experiencing severe pain in the left side of my face, extending into my left ear. I was diagnosed with trigeminal neuralgia and referred to UPMC Neurosurgery Associates. Two brain surgeries, multiple procedures and medications did not stop the pain. The neurosurgeon wanted to refer me to the UPMC Eye and Ear Institute, however, I have Highmark insurance through my wife’s employer, and I was now barred from access to any additional UPMC providers. Over the next 2 years, I saw five in-network ENT’s, all of whom told me that it was the nerve condition causing the pain. Then in early 2018, my dermatologist discovered evidence of cancer in my ear. I had been misdiagnosed all along.

It took 6 years to find a team of doctors who were able to help me, only to face the reality that I would lose them in a few short months when the Highmark/UPMC Consent Decree was set to expire. This included my team at Hillman Cancer Center. I was told that my only option was the Cleveland Clinic, which is 2 hour drive from Pittsburgh. The idea of being cut off from my doctors was terrifying.

Patients, local leaders and advocates banded together demanding that UPMC negotiate with Highmark to guarantee access to the providers and services that were in patients’ best interests. Highmark was willing to negotiate, but UPMC refused. With Attorney General Josh Shapiro’s involvement, at the eleventh hour an agreement was reached and a ten-year contract was signed. That agreement finally allowed me to quit fighting for my healthcare and to begin caring for my health.

I have always said that this is not just about me, it’s about thousands like me. If my legacy can be that I helped even one person avoid what happened to me, then I can be proud that I did something important and meaningful in my lifetime.
consultation with community representatives, contained few concessions to residents’ needs, and included no accountability provisions.\textsuperscript{105}

UPMC was forced to give ground on the question of patient access when, following a massive demonstration at UPMC’s annual public board meeting,\textsuperscript{106} Pennsylvania Attorney General Josh Shapiro used our state’s strong charity laws to restore patient access for Highmark subscribers with cancer and other life-threatening illnesses.\textsuperscript{107}

UPMC’s marketing and publicity often foreground its contribution to surrounding communities by tabulating the benefits it provides. In 2020, UPMC estimates the total worth of these benefits — which include Medicaid shortfalls, medical education, and gifts to a variety of not-for-profits — at about $1.7 billion.\textsuperscript{108} These benefits are indeed valuable. But they have not proved adequate to provide what the people of our region most want, and that is good health. Nor is the critique of UPMC’s investments and impact limited to a “motley” band of outsiders or malcontents. It is a critique that has been elaborated by public health researchers and professionals,\textsuperscript{109} healthcare economists,\textsuperscript{110} and regional health experts\textsuperscript{111} as well as elected leaders and community organizations. It is not healthy when caregivers live in poverty and avoid medical treatment because they can’t afford the copays. It is not healthy when doctors and hospitals issue pink slips to people who are frail or ill. It is not healthy when a tiny group of people at the top of a tall tower threaten to close hospitals in medically underserved areas simply because affected people would like to improve their plan.

Our experience as employees, patients, caregivers, and advocates has taught us that whether or not we can turn our healthcare resources into community health depends on power. Upstream from wages and benefits, upstream from access to care, upstream from equity and disparities, is the question of who sets the agenda. Who has a seat at the table where decisions are made and who is deemed an outsider? Whose pain is taken seriously and addressed and whose is dismissed?\textsuperscript{112}

As we turn our attention to recommendations, our fundamental premise is this: reducing inequity and improving our region’s health requires a more fair and balanced distribution of power, the most basic social determinant of health.

**Recommendations**

**Caregiver Interventions**

1. **Support union organizing in UPMC facilities.** Unions give workers power and help transform care-giving into a source of good health, particularly for women and people of color. UPMC can support union organizing by agreeing to allow workers to choose for themselves, free of harassment and interference. Elected officials should make unions a policy priority and, in addition to supporting legislation like the PRO Act\textsuperscript{113} at the federal level and Representative Dan Miller’s HB 1047\textsuperscript{114} in Pennsylvania, use organic points of contact between city, county and state government and UPMC, such as contracting and grant-making, to encourage labor peace and labor management cooperation.

2. **Work to raise minimum pay for service workers to $20/hour immediately,** not in the distant future by which time the value of the increase has been offset by cost of living increases. In conjunction with housing and education policies, raises that bring workers to this level provide a path to economic security. The City of Pittsburgh and Allegheny County can lead the way and can also make this goal an explicit part of healthcare policy. Wage data should be collected and reported as part of every healthcare dashboard.

3. **Eliminate medical debt for caregivers** and stop reporting medical debt to credit agencies, so that everyone is encouraged to seek and receive treatment recommended by their doctors. Each year, UPMC reports bad
debt and charity care as a significant portion of its community benefit. Employees should be helped to understand that their health is important and that these benefits are available to them.

4. **Act swiftly to create sustainable paths to safe-staffing.** Elected officials can help by supporting revision of Pennsylvania’s outdated hospital regulations to include safe-staffing provisions and by questioning new hospital expansion where understaffing is chronic in existing operations.

**Community Interventions**

UPMC is a heavily subsidized public charity with an obligation to the communities that sustain it. These obligations can only be met through structured, truthful and accountable dialogue.

1. **Restore and enhance accountable community voices to UPMC’s corporate board.** It’s time to put unions, community care advocates, and others who speak for workers and community stakeholders back on UPMC’s Board. It is also time to bring racial, gender, and income balance to the Board. This can be accomplished swiftly, in the same way that the Board was downsized in 2011.

2. **Make UPMC investment and operations more responsive to our communities’ needs by negotiating a robust community benefits agreement.** Since UPMC’s hospitals affect patients, workers, and taxpayers who reside outside the immediate neighborhood of any given hospital, parties to this agreement should include UPMC corporate, the City of Pittsburgh, the healthcare union and community health representatives, as well as neighborhood organizations who may have a vested interest in UPMC’s development. Financial contributions should come in the form of unrestricted funds, allowing Pittsburgh residents, through their elected representatives, to have a say over how our healthcare dollars are invested.

3. **Refine and update existing regulations and codes to enhance community accountability.** For instance, Pittsburgh’s procurement standards contain provisions that disqualify entities that violate state and federal law. Contracting, zoning, anti-discrimination and indeed public charity laws should be rigorously enforced and can be enhanced to reduce harm, protect the public’s interest in our charitable health assets, and promote alignment between private institutions and public values.

4. **Require Pittsburgh and Allegheny County’s Controllers to regularly assess local tax subsidization of UPMC facilities.** Both entities have helped to spark important community conversations by gathering, analyzing, and publishing this information. It should be a regular feature of local financial dashboards.
“A union at UPMC would be a good thing for Pittsburgh. Regardless of how much UPMC fights it, the ability to bargain for fair wages, pensions, and healthcare is the only way to close the gap between white Pittsburghers and Black Pittsburghers. We deserve to live too. We deserve our health too. We deserve to enjoy our families too. We need to build the city up for real people like me.”
Endnotes


4. Our understanding of the historical relationship between the steel and healthcare industries is indebted to Gabriel Winant’s excellent and pathbreaking “The Next Shift: The Fall of Industry and the Rise of Health Care in Rust Belt America,” Harvard University Press, 2021. Here and the section below we draw from that volume, from Winant’s testimony before the PA Senate Democratic Policy Committee in July of 2021, and from a Zoom event held with n+1 Magazine, Winant, Representative Summer Lee, Lisa Frank of SEIU Healthcare and UPMC workers Nina Payton and Lou Berry. A description of this event is available at https://www.nplusonemag.com/online-only/events/the-next-shift-a-virtual-discussion-2/.


11. Winant Testimony.


17. For a discussion of this trend in the healthcare industry see “The Next Shift” at 256.


22. Allegheny County Profile, August 2021, https://www.workstats.dli.pa.gov/Documents/County%20Profiles/Allegheny%20County.pdf. The sector with the next highest percentage of the county’s total workforce is Retail Trade, which accounts for 9.8%.


24. Id.


52. Pittsburgh Wage Study Committee at 15.


55. Pittsburgh Wage Study Committee at 15.

56. Pennsylvania Department of Education, 2020-2021 data https://www.education.pa.gov/DataAndReporting/LoanCanLowIncome/Pages/PublicSchools.aspx


59. Pittsburgh Wage Study at 17.

60. In 2013 UPMC chose to litigate rather than comply with affirmative action audits that would allow us to understand the composition


63 Levine at 55-56.


66 Pittsburgh Wage Review Committee at 29.


68 Pittsburgh’s Racial Demographics at 4.

69 Pittsburgh’s Racial Demographics at 37.

70 Pittsburgh’s Racial Demographics, Appendix 4.9 at 113.

71 Pittsburgh Gender Equity Report at 21.

72 Pittsburgh Gender Equity Report at 23.

73 Pittsburgh Wage Review Committee at 19.


76 Pittsburgh Wage Review Committee at 21.

77 Pittsburgh Wage Review Committee at 21.


79 Pittsburgh Wage Review Committee at 21.


81 Lawrence Mishel and Jessica Schieder, “As union membership has fallen, the top 10 percent have been getting a larger share of income,” Economic Policy Institute, May 24, 2016, https://www.epi.org/publication/as-union-membership-has-fallen-the-top-10-percent-have-been-getting-a-larger-share-of-income/.

82 Id.


89 Pittsburgh Wage Review Committee at 25.


92 “Hidden in Plain Sight: The Cost of UPMC Tax Exemptions,” Pittsburgh United, April 15, 2012 (on file with author) [Hereinafter Hidden in Plain Sight].

93 Hidden in Plain Sight. Allegheny County has not performed a county-wide property reassessment since 2013. This means the value of UPMC’s property tax exemption in 2021 would be approximately the value of their exemptions in 2012, plus the value of the tax exemptions for any property they have purchased in the county between 2012 and 2021. Thus, it is likely to be significantly more than $40 million.

94 Hidden in Plain Sight.

95 Complaint, Pittsburgh v. UPMC, GD-13-005115, p 6 (Allegheny Co. Ct. Common Pleas 2013). Pittsburgh’s tax challenge lawsuit versus UPMC was later dismissed without prejudice on technical grounds. The city was able and expected to correct its complaint and refile
the suit, but Mayor Bill Peduto made a decision to discontinue it.

96 In 2013, UPMC famously claimed it had “no employees,” to the disbelieve of thousands of employees and most people in Pittsburgh. Rather, UPMC argued in response to Pittsburgh’s tax challenge suit, all of the people working in their hospitals and other businesses were employed by subsidiaries. It was these subsidiaries who would be responsible for payroll taxes. See, e.g., Steve Twedt, UPMC maintains it has no employees, Pittsburgh Post-Gazette, November 11, 2013, https://www.post-gazette.com/business/2013/11/12/UPMC-maintains-it-has-no-employees/stories/20131112058.


99 Donald S. Burke, “Health Care or Health? An Existential Question,” [Farewell Address], Graduate School of Public Health, University of Pittsburgh, beginning at 19:10, June 6, 2019, available to view at https://pitt.hosted.panopto.com/Panopto/Pages/Embed.aspx?id=280d08b7-8296-4bd9-9451-aa5d010cf22f [Hereinafter Burke Farewell Address].


101 The zip code surrounding UPMC Mercy Hospital (15219) struggles in a variety of ways when it comes to healthcare access and health outcomes. The Allegheny County Community Health Dashboard, for instance, shows that the age adjusted rate of death from cancer for 15219 is more than 150% the rate for Allegheny County as a whole. The 15219 also has a much higher rate of persons with a disability living in poverty, adults without health insurance, babies with low birth weights, and adults with poor mental health. The overall age adjusted death rate is also much higher. The Allegheny County Community Health Dashboard is available at https://www.allegheny-county.us/Health-Department/Resources/Data-and-Reporting/Chronic-Disease-Epidemiology/Allegheny-County-Community-Indicators.aspx?hcn=%2Findicators%2Findex%2FView%3FindicatorId%3D364%26localeId%3D2297%26comparisonId%3D7209%26fnem-bedredirect_%3D1.


109 See, e.g., Burke Farewell Address.


111 See, e.g., Testimony of Geoff Webster, Pittsburgh Wage Review Committee at 176.

112 Testifying before the PA Senate Democratic Policy Committee, Katrina Rectenwald RN spoke to the role that gender bias plays in denying women treatment for pain -- and for denying women nurses and other frontline healthcare workers real input into their own working conditions. “Rather than act on the glaring inequalities, obscene profits, and poor health outcomes that are generated year after year by the [healthcare] system we have, we prefer to talk women [healthcare workers] out of thinking that their pain is real.” Testimony by Katrina Rectenwald RN, Hearing on the Healthcare Workforce Crisis in Pennsylvania, PA Senate Democratic Policy Committee, July 21, 2021, https://www.senatormuth.com/wp-content/uploads/2021/07/Katrina-Rectenwald-July-2021.pdf.


115 Id.

116 Burke Farewell Address at 19:12.

117 Burke Farewell Address at 19:12.
Pittsburgh United strives to advance social and economic justice in the Pittsburgh region by working to ensure that working families and low and moderate-income communities are able to share in the prosperity that is generated by economic growth and development. As a part of the national network the Partnership for Working Families, we promote strategies that will transform the way that economic development impacts our communities so that all of us may benefit from growth in Pittsburgh’s new economy. With our allies, we use innovative community organizing, research, advocacy and communications methods to further our goals for a just local economy.

PITTSBURGH UNITED
841 California Ave, Pittsburgh PA 15212
412-231-8648
www.PittsburghUnited.org