"We're not the Enemy and We're not Asking for the World": Low-wage Hospital Service Workers' Advocacy for Fair Wages

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“We’re not the Enemy and We’re not Asking for the World”: Low-wage Hospital Service Workers’ Advocacy for Fair Wages

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A number of states and localities have increased the minimum wage beyond that set by the federal government in recognition of the material and health challenges faced by low-wage earners. Academics, economists, and activists have offered microeconomic, economic justice, and moral rationales to support increasing the minimum wage. These justifications can be understood from the vantage of claims-making, that is, the ways individuals and groups attempt to define and shape a social problem to influence policy. This paper examines the wage-related claims-making of low-wage hospital service workers. These workers (N = 156) testified to a City Council-created Wage Review Committee, which posted the testimonies online. We performed a qualitative content analysis on these workers’ testimonies to identify their rationales for higher wages and fair wage rates. Hospital workers’ testimonies brought depth and new understanding to arguments for raising wages. Low-wage workers can be effective advocates for their own interests.

Keywords: claims-making, fairness arguments, minimum wage, low-wage workers, qualitative content analysis
Income inequality in America has been growing since the 1970s, whether assessed by household income, annual earnings, or other statistical measures (Jarosz & Mather, 2018). While not a panacea, one increasingly popular solution to reduce income inequality and address the challenges faced by low-wage workers is to raise the federal minimum wage.

Arguments offered in the minimum wage debate can be understood from the vantage of claims-making, or the process by which individuals and groups attempt to define a social problem, shape public perception, gather support, and influence policy (Morris, 2015). Embedded in claims are assertions about causation, scope, and consequences, factors that, in turn, are used to point to a solution (Best, 2017b). In this paper, we explore the claims for higher salaries that a group of low-wage hospital service workers made as they testified to a City Council-appointed Wage Review Committee. Specifically, we describe how these workers defined the problem of low-wages and what they considered to be a fair wage.

Background

There is no single definition for “low wage” and, therefore, estimates of the number of low-wage workers differ. The U.S. Government Accountability Office (GAO) defined “a ‘low wage’ worker to be an individual who earned $16 per hour or less, measured in constant 2016 dollars” (2017, p. 2). In 2016, according to the GAO (2017), almost 40% of workers between the ages of 25 and 64 met that definition.

Low-wage workers often report living from paycheck to paycheck and describe numerous challenges in meeting their families’ basic needs. Many face multiple hardships including food insecurity (Gundersen & Ziliak, 2018; Nord & Parker, 2010), housing instability (Heflin, 2017; Phinney, 2013), and utility cut offs (Heflin & Butler, 2013; Hernández & Bird, 2010). Low-wage workers struggle to save for emergencies (Rothwell & Sultana, 2013) or plan for retirement (Gonyea, 2007; Grinstein-Weiss et al., 2015). They frequently are unable to afford health insurance, health care, or prescription medications (McCarron, Zimmerman, Ralston, & Martin, 2011; Schmitt, 2012); delay needed treatment even when confronting serious health issues (Heflin, 2017; Neckerman, Garfinkel, Teitler, Waldfogel,
& Wimer, 2016); and report poorer health status (Wu, Wang, & Eamon, 2014). To make ends meet, low-wage workers may use public benefits or charity, fail to pay bills in a timely fashion, or rely on assistance from family or friends; they often live one unforeseen expense away from a crisis (Cooper, 2016; Danziger, Wiederspan, & Douglas-Siegel, 2013; Purtell, Gershoff, & Aber, 2012; Spielberger & Lyons, 2009; Wu & Eamon, 2010).

A solution growing in popularity to address the challenges faced by low-wage workers is to raise the federal minimum wage. The federal minimum wage was set at $7.25 in 2009 and has not been raised since then, although today 29 states and the District of Columbia have minimum wage rates above the federal standard, and 42 local jurisdictions have minimum wages higher than that of their states (Economic Policy Institute [EPI], 2018). In 2012, service workers in New York City marched to demand an increase in the minimum wage to $15 an hour. This effort has come to be known as the Fight for $15 and this wage level has become an aspiration for those advocating higher minimum wage rates (Fight for $15, n.d.; Greenhouse, 2015; Rolf, 2016); it will become a reality over the next few years in some parts of the country (EPI, 2018).

One argument made about raising the minimum wage is related to effects on employment. Proponents assert that despite opponents’ contentions that a minimum wage increase would negatively impact employment (Beaudry, Green, & Sand, 2018; Lammam, 2014), there has been little effect (Reich, Allegretto, & Godoy, 2017; Tung, Lathrop, & Sonn, 2015). Benefits of raising wages include reducing turnover, improving productivity, decreasing use of tax-supported public programs, and reducing poverty (Allegretto et al., 2013; Cooper, 2013; Jardim et al., 2018).

A second argument is framed around market fairness and economic justice. Advocates assert that the market is not an impartial institution; rather, market outcomes are influenced by economic power and gender and racial biases (Pietrykowski, 2017). Historical differences of privilege in American society continue to be expressed in current pay rates. Thus, the skills possessed by low-wage workers, who are disproportionately women and people of color (Bivens, Gould, Mishel, & Shierholz, 2014; Clark, 2014; Tung et al., 2015), are inadequately valued in the work performed (Pietrykowski, 2017).
A third argument suggests that there is a moral imperative and ethical responsibility to pay workers a decent wage (Konigsburg, 2017; Rogers, 2014). The argument is simply that no one working full time should remain in poverty. At minimum, workers should receive a living wage, that is, a wage that supports a full-time worker and his/her family’s basic needs (Fabo & Belli, 2017; Parker, Arrowsmith, Fells, & Prowse, 2016). Further, a living wage would enhance human dignity by respecting the worth of low-wage workers themselves and their contributions (Konigsburg, 2017; Pietykowski, 2017).

These arguments can be understood as forms of claims-making, or the process by which social actors attempt to persuade others that a condition is problematic and should be addressed (Best, 2017b). Claims are arguments put forth to demonstrate “that X is a problem, that Y offers a solution to that problem, or that a policy of Z should be adopted to bring that solution to bear” (Best, 1987, p. 102). Encompassed in the rhetoric of claims are assertions about the magnitude of the problem, its causes and consequences, and means of addressing it.

Claims can entail “verbal, visual, or behavioral statements” (Loseke, 2017, p. 26). They may appeal to people’s emotions, depicting victims as well as victimizers, and/or to their logic, identifying costs as well as benefits. Because they are intended to persuade, actors can construct claims about a particular matter differently to be convincing to different audiences (Best, 2017b).

Different social actors can offer different definitions of a social problem and the policy solutions to ameliorate it (Best, 2017a; Griffiths & Best, 2016; Parkinson, 2004). According to Best (2017b), “even people who are allied in a claims-making campaign may adopt different rhetoric; the claims of activists and experts often emphasize different elements” (p. 25). This is clearly the case with efforts to raise the wages of low-income workers. Activists, researchers, and other stakeholders have framed a variety of arguments about the benefits or costs of raising the minimum wage, and have argued, often with great passion, for their positions.

In this paper, we examine claims-making arguments for raising wages from the perspective of low-wage hospital service workers. We examined low-wage hospital service workers’ public testimonies offered to a City Council-appointed Wage Review Committee. In providing public testimony, the hospital service workers were asserting claims about why a wage
increase is needed and what it should be. Their perspective is underrepresented in the literature and offers unique insight into the situations, hopes, and demands of those directly affected by low wages.

Methods

Hospitals are the largest private employers in the region, and two competing nonprofit health networks dominate the delivery of health care services in Pittsburgh and Allegheny County. Efforts to unionize hospital service workers at the two health networks failed at one site (Hospital System A), but ended in a vote to join SEIU in June 2015 at Hospital System B’s largest hospital (Nuttall, 2015). Four months later, the Pittsburgh City Council appointed a Wage Review Committee charged with holding public meetings and making recommendations about hospital service workers’ wages and employment conditions.

The six-member Wage Review Committee, headed by a member of the City Council, held two days of public hearings on October 22 and 23, 2015, at which hospital service workers, other members of the public, and experts testified. The Wage Review Committee’s final report, including all of the testimonies, was posted online and made available to the public at no cost (“Report of the Wage Review Committee,” 2015). We analyzed the testimonies to discover how hospital service workers viewed their situations and advocated for themselves at the hearings. The analysis did not require IRB approval because it involved publically available data, according to the University of Pittsburgh’s IRB.

In addition to 20 experts, such as academics or economists, 171 individuals testified before the Committee. Fifteen of these individuals were not employed by one of the two health networks at the time of the hearing or were not hospital service workers; those individuals were screened out of our analysis, leaving 156 hospital service workers and their testimonies. Because there was no set format for the testimonies, their length and content varied greatly. Some hospital service workers confined their remarks to one or two sentences, whereas others spoke in paragraphs, offering very detailed comments. Two of the four coders who took part in this content analysis read through the 156 testimonies to record whatever demographic
and background information was available. However, many individuals did not mention these traits, resulting in a high proportion of “not mentioned” codes for these indicators.

Table 1 presents the demographic and background characteristics of the testifying hospital service workers. Illustrated in Table 1 are the types of jobs defined as “service work” in these hospital systems.

We performed a content analysis of the 156 testimonies using an iterative approach in which thematic codes were specified and refined. Of the four coders, two were students, one was a faculty member with some coding experience, and one was a former faculty member with many years of experience with qualitative research methods; the most experienced member (lead coder) trained the students, wrote coding decision memos, and oversaw the coding of all the transcripts.

We began by identifying several general content areas or broad themes. All coders read the same 20 transcripts and independently identified and assigned codes to narrative segments reflecting subthemes within the general content areas. This process of coding a discrete number of transcripts, comparing coding decisions, and suggesting new codes was repeated three additional times until there was consistency in the application of codes and no new themes were identified, at which point the lead coder produced a definitional memo for the group’s use. Finally, the lead coder reread all of the coded narratives to identify statements in which workers discussed what wages they deserved and why.

The content analysis resulted in 166 blocks of coded text of varying length. We identified four themes related to how workers justified their claims that it would be fair for them to receive higher wages (i.e., how hospitals function, other work-related factors, comparative considerations, and commonly-held beliefs) and two themes concerning the wage rate workers thought would be fair (i.e., at least $15 per hour, or a “livable” wage, without specifying an amount). The quotations used in the findings are from 32 individuals (20.5% of those testifying).

We employed several procedures to ensure the quality of our study’s findings, consistent with the concept of trustworthiness as used in qualitative research (Elo et al., 2014; Lietz & Zayas, 2010). First, we committed to a transparent and collaborative process wherein all four coders assumed active roles
Table 1. Demographic and Background Characteristics

<table>
<thead>
<tr>
<th>Demographic &amp; Background Information</th>
<th>(N=156)</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital System</td>
<td></td>
<td></td>
</tr>
<tr>
<td>System A</td>
<td>86</td>
<td>55%</td>
</tr>
<tr>
<td>System B</td>
<td>70</td>
<td>45%</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>56</td>
<td>35%</td>
</tr>
<tr>
<td>Female</td>
<td>98</td>
<td>63%</td>
</tr>
<tr>
<td>Cannot Determine</td>
<td>3</td>
<td>2%</td>
</tr>
<tr>
<td>Children/Grandchildren</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mentional having children/grandchildren</td>
<td>61</td>
<td>39%</td>
</tr>
<tr>
<td>Mentional not having children/grandchildren</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>Did not mention children/grandchildren</td>
<td>94</td>
<td>60%</td>
</tr>
<tr>
<td>Years at the Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mentioned number of years</td>
<td>63</td>
<td>40%</td>
</tr>
<tr>
<td>(Mean = 14.2 yrs; Range 2.5 - 38 yrs)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mentioned “more than 30 years”</td>
<td>2</td>
<td>1%</td>
</tr>
<tr>
<td>Did not mention length of employment</td>
<td>91</td>
<td>59%</td>
</tr>
<tr>
<td>Hourly Pay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mentioned amount earned per hour</td>
<td>56</td>
<td>36%</td>
</tr>
<tr>
<td>(Mean=$13.29/hr; Range $9.56-$19.40/hr)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mentioned earning “less than $15/hr”</td>
<td>9</td>
<td>6%</td>
</tr>
<tr>
<td>Did not mention hourly pay rate</td>
<td>90</td>
<td>58%</td>
</tr>
<tr>
<td>Position in Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mentioned position held</td>
<td>82</td>
<td>53%</td>
</tr>
<tr>
<td>Type of position mentioned</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clerical (i.e., administrative asst., telephone operator)</td>
<td>8</td>
<td>10%</td>
</tr>
<tr>
<td>Catering/Food Services (i.e., catering coordinator, cook, food services assoc.)</td>
<td>14</td>
<td>17%</td>
</tr>
<tr>
<td>Housekeeping/Environmental Services (i.e., envir. servicees assoc., floor tech)</td>
<td>19</td>
<td>23%</td>
</tr>
<tr>
<td>Nursing/Patient Care (i.e., nursing asst., cardiac monitor tech., patient transporter)</td>
<td>16</td>
<td>20%</td>
</tr>
<tr>
<td>Service (i.e., medical asst., parking, unit secretary)</td>
<td>21</td>
<td>26%</td>
</tr>
<tr>
<td>Technical (i.e., OR tech, nuclear med. tech)</td>
<td>4</td>
<td>5%</td>
</tr>
<tr>
<td>Did not mention position held</td>
<td>74</td>
<td>47%</td>
</tr>
</tbody>
</table>
in identifying themes and sub-themes. Second, we employed peer debriefing to reconcile coding differences and to refine the codes. Third, we maintained a detailed audit trail of all coding decisions. Fourth, the two experienced members of our team thoroughly discussed the final coding decisions that were made, as well as the interpretation and presentation of the findings. Finally, we used a form of member feedback wherein two individuals who are engaged in union organizing with hospital service workers reviewed the manuscript; we specifically asked them to comment on the extent to which the findings and interpretations were consistent (or not consistent) with their experiences with this population and whether we were successful in honoring the workers’ voices. Their comments informed the final revisions of this manuscript.

Findings

The overwhelming majority of hospital service workers spoke of the challenges they faced living on a limited income. They characterized their situations as “barely making it” (male, Hospital System A), “struggling to make ends meet” (female, Hospital System B), and “barely scraping by” (female, Hospital System B). They described the uncertainty of not knowing whether they could pay their monthly bills and the fear of what an unexpected expense, such as a medical illness, a car repair, or an appliance replacement, could do to their fragile finances. They spoke of multiple financial obligations, of prioritizing when to pay each bill, and of making budgetary tradeoffs, such as buying food but doing without medicines, or paying for utilities, but forgoing cable television. They described living without “frills” and wondering if they would ever be able to retire.

Bound by ties of family and place, as well as by a lack of training, degrees, or transferrable skills, the hospital service workers could not (or would not) move to find other jobs. Instead, they sought to change the conditions of their employment. As one worker acknowledged: “It’s hard to stay here in Pittsburgh knowing that I could be making more money elsewhere. But this is my home and I want to fight to change things for the better” (female, Hospital System B). Thus, they used their chance to give testimony to call for higher wages—wages that, in their estimations, would be fair and could ease the challenges
they and their families faced. Many thanked the Wage Review Committee for giving them the opportunity to be heard.

*What Hospital Service Workers Want: Conceptualizations of Fairness*

Those testifying before the Wage Review Committee presented a fairly straightforward claim: low wages created their hardships, therefore, higher wages could reduce (or eliminate) those hardships. They based their arguments for increasing their wages on four core themes: how hospitals function, other work-related factors, comparative considerations, and commonly held beliefs. Embedded in each of these themes and tying them together is a notion of what would be just or fair compensation, an implicit understanding of what would constitute a more equitable exchange between employer and employee. Thus, individually and as a group, hospital service workers’ claims represented a series of arguments coalesced around the principle of social justice.

*The centrality of invisible work(ers) to hospital functioning.* Contemporary hospitals are complex institutions requiring a varied workforce to provide patient care and treatment. Despite the use of increasingly sophisticated medical technologies, hospitals still need a sizable workforce with diverse skills in order to operate. Often, hospital staff must function as a team to ensure effective interventions and continuity of care.

Unfortunately, hospital service work – and those who perform such tasks – is not just undervalued, but is essentially invisible. However, the hospital service workers were clear that the work they performed was valuable and contributed to the functioning of the hospitals. As one worker averred: “Without us, the hospital wouldn’t be open” (female, Hospital System B). She argued:

*I’ve been working at Hospital B in housekeeping for nine years. I love my job. I provide a clean service that the hospital needs to remain open and make sure patients have a clean bed to stay in while we’re [sic] sick and recovering. That clean bed is their home away from home.*
Those testifying also described the dangers that could arise for patients if they did not perform their jobs well.

And for me to be on the front lines doing something like that again, I mean, I could be bagging groceries at Aldi’s and making more money than trying to save this 34-year-old man’s life...I’m in charge of 24 beds, so 24 patients on my one floor I’m responsible for. (male, Hospital System B)

I have been working in the hospital for 30+ years starting at $3.00/hr. I believe we have very important duties that can sometimes put a patient’s life in danger. To work at a minimum and somewhat above minimum wage doesn’t seem to fit with the serious work we do. (female, Hospital System B)

Their commitment to their jobs, their co-workers, and the patients and family members with whom they work was evident in such comments as “I love my job and I love my patients and the people I work with...” (male, Hospital System A) and “I’m a hard worker. I’m there to help my patients and my co-workers...” (female, Hospital System B). They saw themselves as part of “the team” and as sharing in the hospital’s mission. This was true even when their jobs did not involve direct patient care:

As a parking cashier, I am often the first person patients and their families see when they arrive at the hospital and the last person they see before they leave. Our executives tell us that we are ambassadors for the hospital, and to be honest I take that pretty seriously. I think of myself as the face of Hospital B. The people I interact with every day are going through all kinds of things. (male, Hospital System B)

Yet, too often, the workers felt their contributions were overlooked by administrators. As one worker said: “Hospital workers don’t feel important anymore. We feel like a number, something to be used and discarded” (female, Hospital System B).

Other work-based arguments. Many of the hospital service workers argued that they merited higher wages based on one or more work-related factors, such as the number of years worked,
the experience they brought to the job, or the amount of work performed. For example, one worker, who based her claim for higher wages on her length of service and training, said:

The wages are too low given the experience I bring. I have 18 years of experience, a diploma and certification in pharmacy, and an associate’s degree. It’s upsetting, when I think about all the work I’ve put in, to be offered only $14 an hour. What is my experience for? What is my certification for? (female, Hospital System B)

Several described decades-long work careers at their hospitals. However, they claimed their earnings did not match the length of their service. Any raises they had received were consumed by higher health insurance premiums, higher taxes, increased living costs, and reduced public benefits, leaving them feeling little better off than they were before. They questioned the fairness of working for so many years, yet earning so little they could never get ahead.

After my last raise of 34 cents, I now make $15.48 an hour. I don’t think it should take 25 years working at the hospital to get to $15 dollars an hour. (male, Hospital System A)

I’ve invested 26 years of my life in Hospital B. I started out at $9.75/hour and now I earn $16.77/hour, so I have gotten raises over that time. But the thing is, if I get a raise and then have to put it all toward higher insurance costs, am I really getting a raise? It doesn’t seem like it. (female, Hospital System B)

Others rooted their claims for higher salaries in the increasing workloads and responsibilities they had experienced. Because of the relatively low pay, there can be high staff turnover, which can leave units understaffed and/or with a constant stream of new and inexperienced employees. “People are always looking for a better paying job...there is constantly new, inexperienced staffing that makes it unsafe for patients” (female, Hospital System A). Further, those testifying described an ever-expanding scope of work: cleaning more rooms, delivering more meal trays, caring for more patients, or sterilizing more instruments.
And you’re not being rewarded with a salary, with a livable salary. You’re still struggling every two week but the workload increases. It’s like the beds the beds [sic] in the hospital have increased so our work increases. But the pay never increases. (male, Hospital System B)

It’s a lot of work. It’s a huge amount of work, it’s a lot of work. So, just that alone I would take a pay hike for the just work alone, for just the amount of work. (female, Hospital System A).

Further, those who remain at these jobs for any length of time became the “old hands” and often are asked to orient new staff, on top of their regular responsibilities.

*Comparative arguments.* The hospital service workers contrasted their financial situations with those of the senior management and the overall hospital systems. These arguments were most frequently, although not exclusively, made by hospital service workers employed by Hospital System A, where the annual salaries of top administrators are well known in the local community. For instance, news reports put Hospital System A’s CEO’s 2017 base salary at just under $1,000,000 and total compensation package at around $6,000,000 (Gough, 2018). It is not surprising to find that workers were acutely sensitive to the disparity between their salaries and the CEO’s. As one worker pointedly remarked: “Hospital executives are making big bucks, and we are eating crumbs off the table” (female, Hospital System A). Another succinctly said, “They [Hospital System A’s administrators] should share the wealth—there’s enough to go around” (female, Hospital System A).

None of the hospital service workers asked to earn millions each year; none claimed they merited the same compensation as senior managers. Rather, they questioned why they had to work so hard and face such hardships when their employers appeared to be doing so well and the hospital systems seemed to have sufficient funds to make cosmetic and capital improvements.

I see Hospital System A spending money on things at work-like air conditioning units, furniture for the patient rooms. They have remodeled bathrooms, plasma TV sets for the patient rooms, they’re really expensive TV sets, marble bathrooms. Just mainly, just material things for the hospital. I wonder why there’s not more money for the people who work
there...I think the money should also go to the workers that work there so hard. (male, Hospital System A)

Those with children wanted a chance to do with their offspring the kinds of things done by their superiors with greater financial security. They contrasted their families’ lives with those of individuals in more privileged, senior hospital positions. The comparisons highlighted the ways low wages constrained the workers’ families’ circumstances and life choices, and the workers laid claim to their right to commonplace aspects of family life, which those higher up in the hospital systems’ bureaucracies took for granted. A mother working for Hospital B said:

My children deserve a home that’s ours. I want to take my children on a trip to Disney one day, like the VP, management, and our high paid coworkers do. I put in the work. I deserve the pay, so that for once me and my children can live comfortably. Not paycheck to paycheck—that’s not living.

Similarly, a father employed by Hospital System A argued:

I mean, I have to work two jobs and that’s, that’s less time that I spend with my family which I like for, you know, the management and higher ups, they get a chance to go home every day to their family because they don’t have to worry about it.

Commonly held beliefs. Hospital service workers articulated several commonly held beliefs for why their wages should be increased. One was that hard work should pay, that those who do their jobs conscientiously should not have to scrape by. “People who work full time should be able to pay their bills, period” (female, Hospital System B). Those who worked diligently, displayed competence, and were reliable and honest contributed to the hospitals’ functioning, they argued, and deserved adequate compensation. A hospital service worker who began her career in food services before taking a job in the pharmacy elaborated on this view:

I’m a worker—I’m great at what I do...Started in dietary...in 2006—when I was the tray line worker. I was one of the only employees who could do every position. Then I moved to hosting floors. Then I moved to the café, because I got an
extra 50 cents. I was the fastest cashier there was, with my drawer never being short…I also did banquets for doctors, whoever was having an event at the time wanted me to set their event up.

Then there was the downsize…My director at the time knew my capabilities and the person I was, so he got me a job at Hospital B on the grill, where I was for two and a half years... Then I had the opportunity to get into the pharmacy, where I am now. I am the apothecary...No matter who you get, it won't get done like I do. I just need more pay for what I do. Me and my family just need a little more. I’m a single parent of three. I have to work two jobs to make my ends meet. I can’t even afford to pay my children's healthcare, and I work for this big old company. So my kids are on CHIP—and I work for one of the biggest companies in the city. (female, Hospital System B)

Some invoked the American Dream. In a region built by coal and steel (and heroic labor struggles), hard work at one time could pay off for people with high school educations. Home ownership, reliable health insurance, and a retirement pension were real possibilities.

You know, I think that I mean they should be able, those jobs should be paying well enough to, to allow people to live decently without having to go back to college. I mean I don’t see anything wrong with that. I mean whenever the steel mills were around none of those guys went to college, you know… (male, Hospital System A)

However, the mines and mills have long been shuttered. Today, the education and health service sector employs the largest number of people in the metropolitan statistical area (U.S. Department of Labor, 2018), with local healthcare support positions paying a median annual income of $23,345 in 2016 (Deloitte, Collective Learning, & Datawheel, n.d.). According to one hospital service worker, wages at that level mean “there’s no path to the middle class anymore” (male, Hospital System A). Another flatly stated:
The reason I am pissed, is because I cannot think or even conceive of how I can achieve the American Dream which is advertised on television all the time—owning a home, owning a car, sending my grandkids to college. For me, these things are unattainable. And I can’t think of a way to move to a better neighborhood or even moving at all. (female, Hospital System A)

Not only has the American Dream seemed to slip from their grasps, but many felt their smaller, more personal hopes for the future were also in doubt. “If you’ve ever had a dream you know how this feels, except in this case there’s a very small chance that your dream will become reality when year after year you only see 2% raises on your paycheck” (male, Hospital System A). They acknowledged the fragility of their dreams and were aware that achieving them might entail significant costs, if they could be achieved at all.

I would like to go back to school as soon as I can but I am worried about going to part-time and having to pay even more for my benefits, or worse, losing them all together. (female, Hospital System A)

All we want is to be able to have a decent life—maybe finally afford the honeymoon we never got to take, or to go out for a nice date together. (female, Hospital System B)

I plan on retiring when I turn 62. That would mean 47 years of work for this hospital. It probably means that my husband and I will have to live off of peanut butter and hot dogs...(female, Hospital System B)

Finally, wages serve a symbolic function in America as a valuation of a person’s worth. Those who earn more, according to this commonly held belief, are worth more, and by extension are worthier. A worker’s pay rate is seen as providing a measure of his/her value to the employer, which, in turn, can affect how the person feels about him/herself. A male worker at Hospital System A declaimed:

That’s what Hospital System A thinks I’m worth. How do you think that makes me feel?? Well, let me tell you: it makes me feel like a speck and just another body mopping the floors. It’s outrageous.
Another said, “Living this way [financially struggling], we all have feelings of depression and hopelessness” (male, Hospital System A).

A person’s wages also can influence his/her relationship to the community more generally. From where one lives to how much one spends to what kind of transportation one uses to which schools one’s children attend, are all shaped by income. And members of the community evaluate each other on these types of criteria. Despite working full time, hospital service workers who try to stretch their earnings by using government programs or assistance from nonprofit agencies all too often felt that they were seen as less worthy.

I hear some complain about families being on welfare, but this is why. Wages cannot sustain families in this area, so you have mothers and fathers putting in long hours at jobs, and for what? They still need to rely on public assistance. Low-wage workers are unhappy because no matter how hard they work, it’s never enough. It’s hard to feel good about yourself when you can’t provide for yourself or your family. (female, Hospital System B)

What Would be a Fair Wage?

So what did the hospital service workers want? What did they believe they deserved? How much did they think would be a fair wage? Few of those giving testimony identified specific wage rates. Three argued that they should get $16 an hour based on their length of service; two claimed $18 per hour would be a fair wage rate for them; and one thought her base pay should be $20-$21. More often, they talked about what a minimum hourly rate should be, instead of an exact amount. All who cited a minimum wage for hospital employees set it at $15 per hour, most likely reflecting the influence of the Fight for $15 movement (Fight for $15, n.d.; Rolf, 2016).

Those making less than $15 per hour thought that earning that amount would change their lives. It would mean they “wouldn’t worry so much” (female, Hospital System B), could have “extra money to actually save” (female, Hospital System
A), and might even be able to “move to a better neighborhood” (male, Hospital System B). Quite simply:

I will tell you what we told our management. We want $15 per hour for all hospital workers. When I get to $15 per hour, I will go to the grocery store instead of the food bank. We will eat meatloaf instead of hamburger helper. I will eat a little more myself.

Imagine if thousands and thousands of workers around Pittsburgh could make $15 per hour. Moms could provide for kids. Fewer people would be on welfare. More people would be in the shoe store, getting shoes for the kids. You’d see hard working people getting ahead in their lives.

It’s not just about material things, however. If I could make $15 per hour, it would change how I am viewed in society. Right now, I’m just another statistic on welfare. I am more than that. I want to be viewed with the dignity and respect I deserve. (female, Hospital System B)

Others did not identify a dollar amount. Rather, they talked about “wages that allow me to actually live and not feel the constant stress of wondering if I can pay all my bills” (female, Hospital System B) and having sufficient income “because everyone wants to live comfortable” (female, Hospital System A). They spoke of buying groceries instead of using food banks, being able to afford the health insurance offered by their employers, purchasing new shoes for themselves and their children, dinner out with their spouses, education for their children, and a chance to enjoy retirement when they finally reached that point.

When you can care for your family and take part in events and activities in your community, that fills you with a lot of pride. Raising the wage would return that pride to a lot of hardworking people. (female, Hospital System B)

The hospital service workers who gave testimony to the Wage Review Committee were not “asking for the world” (male, Hospital System A); rather, they argued for a wage that would allow them and their families to live without the stress of constant financial worries.
Discussion

Low-wage workers in contemporary America can experience various material hardships (Gundersen & Ziliak 2018; Heflin, 2017; Heflin & Butler, 2013; Hernández & Bird, 2010; Phinne, 2013) and health and health care challenges (Heflin, 2017; McCarrer et al., 2011; Neckerman et al., 2016; Schmitt, 2012; Wu et al., 2014). The testimonies of the low-wage hospital service workers to the City Council’s ad-hoc Wage Review Committee exemplified this situation. They spoke of living paycheck to paycheck, of balancing on the precipice of financial crisis, and of being uncertain about what the future holds for them, issues identified by others writing about low-wage work and low-wage workers (see for example, Ehrenreich, 2011; Halpern-Meekin, Edin, Tach, & Sykes, 2015; Land, 2019).

The Wage Review Committee hearings offered the hospital service workers a public forum in which to air their grievances—to describe in their own words what their day-to-day struggles were like; what tolls their low wages took on their family life; and what it was like to work ever harder in physically and mentally demanding jobs, yet feel the employer saw one as a number, an interchangeable part in a giant healthcare machine, assertions similar to those made by other low-wage workers in both the U.S. and abroad (Orleck, 2018). However, the hearings were not simply a forum for workers to air their grievances. Rather, the hospital service workers used their testimonies as an opportunity to influence policy makers and repeatedly expressed their gratitude for the chance to be heard by the members of the Wage Review Committee. Their testimonies reflected their desire to shape the argument to justify wage increases, including the minimum wage, and in so doing, the workers acted as claims-makers (Best, 2017a), bringing depth to broader arguments about fair wages, shedding new light on these rationales, opening new avenues of discussion, and putting a human face on the contentions associated with raising wages.

A number of workers offered a different twist to arguments made by Pietykowski (2017) and Bivens et al. (2014) about market fairness and economic justice. Rather than focus on how the skills related to their work were undervalued, the hospital service workers brought to light a basic reality—without their work the hospitals would cease to function. Whether it be interacting
with visitors as they park their cars to cleaning rooms and equipment to preparing food, these workers saw themselves as part of the healthcare team and as making a real difference in the lives of patients and their family members. Yet, the pride they felt in their work and workplaces was not, they said, felt by their employers. For these workers, it was not merely their skills that were undervalued, but their contribution to the overall mission of the hospital was overlooked.

The hospital service workers did not address economic issues such as possible job loss or reduced work hours, potential effects of raising the minimum wage often cited in the literature (Beaudry et al., 2018). However, they did provide a fairness argument based on the economic behavior of their employers. They argued that their wages did not match their education or training, length of employment, or job experience. Further, their wages, they asserted, have not increased, although productivity, as reflected in increased workloads and responsibilities, has. In a for-profit setting, this trend represents a transfer of wealth from labor to employers; in the case of non-profit hospitals, one might ask whether service workers’ low wages subsidize higher wages for others or for other investments that hospitals might make. In this case, the hospital service workers noted senior administrator and physician salaries as well as investments in the hospitals’ physical spaces without a concomitant investment in low-wage workers.

Konigsburg (2017) and Rogers (2014) have laid out ethical rationales for raising wages. Through their testimonies, the hospital service workers portrayed the moral imperative for higher wages in stark terms; they described a living wage as a wage that made life doable for them. They wanted a wage that meant they could meet their basic needs, a wage that would allow them to spend on their families and their children and grandchildren, and a wage that would not require a second job or regular overtime shifts. For some, the moral argument was simply an embodiment of how they described the American Dream.

As demonstrated in these examples, workers’ arguments drew on their lived experiences, not the statistics and abstract concepts often favored by experts. Advocates, policy-makers, and researchers should create space for people to voice their concerns and preferences and integrate those who will be affected by decisions as much as possible into the process. Social
work organizers need to facilitate conversations with those involved to learn how the group(s) defines the social condition of interest, relevant change strategies, and desired outcomes. We should incorporate not just these ideas, but also their terms and phrases into our organizing campaigns and advocacy efforts. Perhaps most important, we should encourage workers to advocate for themselves. The enthusiasm and gratitude of the 156 hospital service workers who testified in Pittsburgh suggest that workers want to be heard about their working lives.

Finally, the aspirations of the *Fight for $15* campaign resonated with a number of the hospital service workers who noted that earning that amount would dramatically improve their lives. Unfortunately, for many workers and their families in Allegheny County (home of this study) and elsewhere, a raise to $15 an hour is not likely to be sufficient in and of itself to cover basic living expenses (Economic Policy Institute, 2019). This reality, in turn, points to a problem with which organizing campaigns must grapple. On the one hand, there is a desire for a succinct and easy to understand slogan to motivate a campaign. On the other hand, at least some workers see it as a cure to their economic challenges and may become disappointed and disillusioned if the impacts of $15 per hour are not as expected. Finding a balance is tricky; people need to be motivated, but social work organizers need to be careful not to overpromise or suggest that a single fix will cure all.

**Limitations**

There are three limitations to these findings. First, although unstructured testimony can offer insights into what is important to low-wage workers, it also can mean that some desired information simply is unavailable. For instance, in these testimonies, demographic information was uneven at best and completely absent in relation to race/ethnicity, thus constraining our ability to compare the characteristics of those testifying with demographic information available from one of the hospital systems. Similarly, though it would have been interesting to situate the workers’ comments in a broader context, such as their involvement in unionization efforts or the *Fight for $15*, we were unable to do so because the workers did not discuss these issues. Second, by its very nature, the researcher in qualitative research is
an integral part of the research process, including the analysis and interpretation of the data (Ben-Ari & Enosh, 2011; Morrow, 2005). Although the coding process and efforts to assure trustworthiness are specific and credible, others might not interpret the testimonies in the same fashion. Third, the testimonies came from a self-selected group of participants willing to testify at public meetings to a government-appointed committee. As Couper and Miller (2008) and Parkinson (2004) suggest, those willing to share their opinions, whether by speaking publicly, volunteering for an interview, or answering an online survey, are not representative of others who may be similarly situated and findings, thus, will lack generalizability. In this instance, the testimonies of the hospital service workers who appeared before the Wage Review Committee do not necessarily represent the sentiments of low-wage hospital service workers at the two local health networks or low-wage workers at hospitals in other communities, no less low-wage workers in general.

Conclusion

The testimony provided by hospital service workers did not use formal terms like equity or social justice or economic justice; instead, they drew on their lived experiences to craft compelling, articulate fairness arguments for raising wages. Their participation illustrated their desire to have a voice in things that could affect their lives as well as their capacity to advocate for their own interests and those of similarly situated workers. In this way, they can be seen as active claims-makers, shaping advocacy arguments and influencing policy makers. This is a point that we, as social workers, should take to heart and continually remind ourselves: we do not need to act “for” low-wage workers, but we can work “with” them, learning from their words, priorities and preferences; ensuring they have the space to exercise their own voice; and sharing with them our knowledge, skills, and values.

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References


