

Hospital Service Work in the Chicago Region and Illinois: Stagnant Wages in a Growing Sector

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EXECUTIVE SUMMARY

As in nearly every state and region in the United States, the healthcare sector has become an important driver of the local economy both within the Chicago region and throughout the state of Illinois. Across the long cycle of declining employment levels in traditional industries like manufacturing and the shorter cycles of recession and recovery since 2000, the health care sector has continued to add jobs. Hospital organizations continue to occupy the focal point of the health care system, but a mix of regulatory and cost-based pressures and incentives have driven a profound and uneven process of restructuring in the industry. Ownership has consolidated into multi-hospital systems even as care has decentralized outside of hospital walls. Some hospitals have closed or reduced services as others have expanded with sizable investments in construction, reorganization, and technology.

In theory, hospitals have the potential to fill a crucial hole left by an increasingly bifurcated labor market. In practice, however, wages have been stagnant for many hospital workers despite increasing demand. This report focuses on workers in Illinois and the Chicago region who are employed in hospital services positions, defined here as healthcare support occupations, food preparation and service occupations, and cleaning and maintenance occupations.

The analysis suggests that:

- The Healthcare and Social Assistance sector accounts for approximately 675,000 people employed in the Chicago region.
- Hospitals remain major employers, although most of the employment growth in the healthcare system has occurred in ambulatory care settings. In the Chicago region, about 180,000 jobs were in hospitals, and about 14,000 jobs were in outpatient care centers in 2017.
- In Chicago, hospital service workers – food preparation, cleaning and maintenance, and healthcare support occupations – make up roughly 1 out of 6 hospital employees (33,000).
- The estimated median hourly wage is under \$15 for healthcare support occupations and under \$13 for cleaning and maintenance and food preparation and service occupations. In addition, wages have been stagnant for hospital services workers. This is despite indicators of increasing industry demand and, on the supply side, increasing educational attainment among this segment of the workforce.
- Approximately 29,000 hospital service workers in Illinois earn below \$15 an hour and 22,000 of them earn below \$13 an hour. Annual median earnings for fulltime Chicago hospital service workers are between \$26,000-31,000.
- Women and workers of color are over-represented in hospital services positions.
- Additionally, for 2012-16, there was an estimated 10,450 women of color employed as service workers in Illinois. Like the entire workforce, hospital services workers are becoming increasingly diverse.

Recommendations:

- Healthcare organizations need to improve the compensation standards of hospital service workers in order to raise their wages above \$15. A proven and robust predictor of higher wages is unionization. Studies of union impacts on hospitals wages have consistently found positive wage effects typically ranging from 3 to 12 percent. Policy and legal measures that protect workers

rights to organize are powerful tools for advancing the incomes of both professional and nonprofessional healthcare occupations.

- Additionally, open pathways to career advancement within the healthcare sector should be provided. To maximize employee welfare gain and distributional equity, investments in hospital-based economic development should be accompanied by strategic attention to workforce training and “career ladder” development. Most career-ladder programs are partnerships involving government workforce-development agencies and some combination of community colleges, unions, community organizations, and employers. Advancement opportunities for workers, along with reasonable compensation levels represent a genuine investment in worker-advancement systems.

As a whole, the evidence suggests that the dramatic growth of the health care system amid a prolonged processes of organizational restructuring and cost-containment have not led to investments in the non-professional hospital workforce.

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INTRODUCTION: HEALTH CARE AND ECONOMIC OPPORTUNITY

Over the past half century, the American health care system has grown from less than 5 percent of the national economy to nearly 18 percent, or roughly \$3.3 trillion as of 2016.¹ Commentators frequently frame the ever-swelling portion of the national economy attributed to health care spending as cause for concern. Health care expenditures account for a significant portion of government budgets at both the state and federal levels. Rising insurance premiums siphon-off wage gains and incentivize employers to limit the extension of employee benefits. Insurance benefits have eroded relative to costs, and medical bills represent the leading cause of personal bankruptcies.

Despite these causes of concern, health care's incessant growth also creates opportunities. Over the last decade, health care expenditures have accounted for over one quarter of the growth of the entire US economy (Emanuel, 2015, Ch.4). Between 2009 and 2016, the US healthcare system as a whole has added over 2.2 million jobs, over 900,000 of which occurred in the final two years.

This sustained process of expansion has affected the labor market and economic development landscape in both small cities and large, diverse urban regions. Many struggling communities have envisioned an expanded role for hospitals and academic medical centers as so-called "anchor institutions": large, relatively place-rooted organizations capable of investing in neighborhoods, employing large numbers, and generating a range of additional economic and social benefits. Moreover, as traditional pathways to "good" jobs have eroded, health care has partly filled the void. While the healthcare economy supports highly paid, specialized professions like

doctors, diagnostic and treatment professionals, biomedical researchers, and those engaged with administrating and managing the health care's organizational, financial and regulatory complexity, it also generates an important source of employment opportunity for lower-earning and less-specialized workers.

The hospital industry in particular provides opportunities for employment across the job quality spectrum. Health care remains dominated by large organizations, which provide rare opportunities for stable employment and career progression for employees at the lower end of the wage spectrum (Fitzgerald, 2006; Nelson and Wolf-Powers, 2010). In theory, such opportunities at large, socially driven organizations could provide access to higher pay and pathways to promotions. However, evidence that such a broad, equitable distribution of opportunity has occurred remains lacking.

With a focus on the Chicago region and the State of Illinois, this report by the Project for Middle Class Renewal paints a picture of employment in the hospital sector, with an emphasis on the lower-end of the employment spectrum, particularly, the service jobs that are crucial to the operation of complex hospitals and hospital systems. In this respect, the report expands on themes identified in recent national and multi-state studies (e.g., National Employment Law Project, 2017; Appelbaum and Batt, 2017) by honing in more locally on the healthcare employment landscape in one region and one state. The report begins by examining how trends in employment levels in the healthcare sector reflect broader patterns of organizational restructuring. The following section presents wages and demographic characteristics of workers. A conclusion summarizes the findings, and the appendix describes the estimation procedure and definitions in greater detail.

¹ See "National Health Expenditures 2016 Highlights"

EMPLOYMENT GROWTH IN THE HEALTH CARE SYSTEM

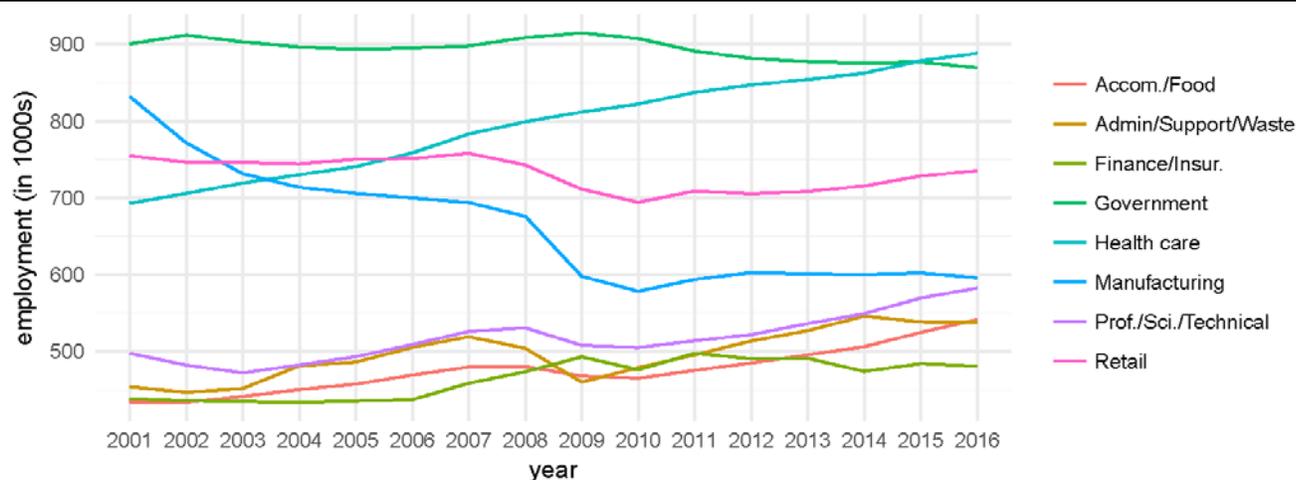
The complex causes and wide-ranging impacts of health care's gradual shift to the center of local economies remain under-appreciated in scholarship on regional economic change and local economic development policy. Components of the health care economy are routinely wrapped into broader categories like the services sector, "Eds and Meds," the "post-industrial" knowledge economy, the "creative class," or some other broad term meant to encapsulate the tectonic shifts of the late 20th and early 21st centuries. However, even setting aside the substantial segment of management and business services, manufacturing, research, and other industries that directly depend on the US healthcare system, employment growth has been striking within the narrower group of industries that, for the most part, actually provide front-line, client- and patient-facing health care services.

According to the Bureau of Economic Analysis, in 2016, private employment in the industry sector defined as "Health care and social assistance" was over 888,000 in Illinois and over 675,000 in the

Chicago Metropolitan Area. Figure 1 compares employment trends in health care since 2001 with other large industry sectors in the state of Illinois. By this measure, health care experienced sustained job growth in Illinois during the recession and surpassed all other private industry sectors² in terms of employment levels in 2006 and even surpassed government employment (state, federal, and local combined) in 2015. Now the largest industry sector (at least according to the straightforward but imperfect approximation of standard industry classifications),³ health care establishments today account for more jobs than any private industry sector or governmental employer – in both the Chicago Metropolitan Area and in the state of Illinois. While not unique to these areas, this milestone underscores the fact that health care has gradually but unquestionably joined traditional leading sectors of the state's economy, such as manufacturing, trade, and – in the Chicago region – the type of white-collar specializations that characterize major metropolitan areas with diverse economies and global aspirations.

The broad health care and social assistance sector includes a variety of industries and establishment

Figure 1: Illinois employment in major industry sectors (2-digit), 2001-2016



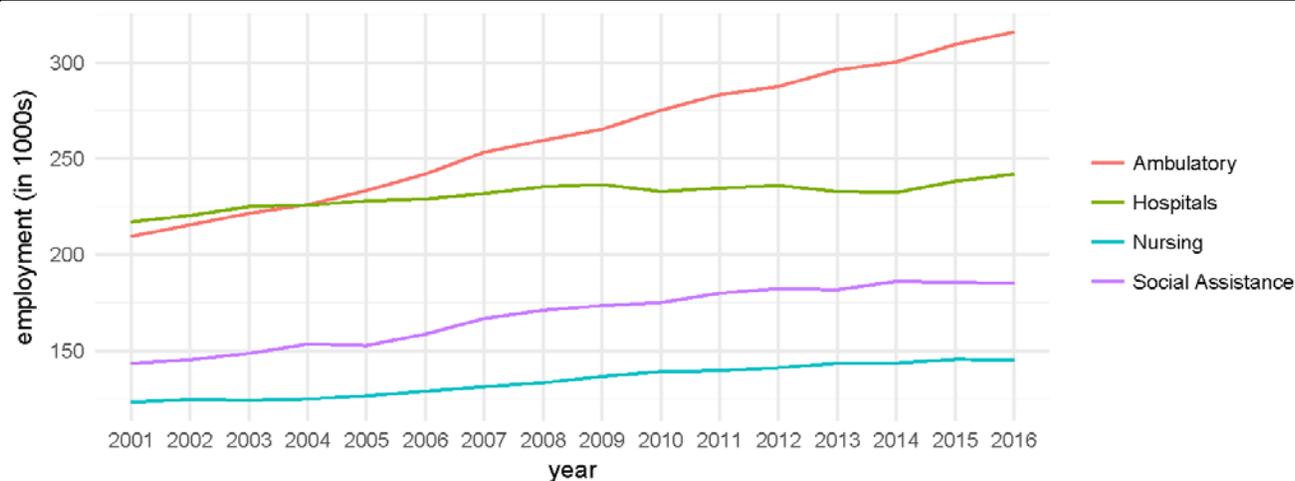
Note: Employment includes full-time and part-time wage and salary employee; data from Bureau of Economic Analysis

² There are many ways of defining industry sectors. The definition here adheres to the hierarchical North American

Industrial Classification System (NAICS) and equates "industry sector" to the 2-digit level of aggregation.

³ See appendix for additional details.

Figure 2: Illinois employment in health care and social assistance industries (3-digit), 2001-2016



Note: Employment includes full-time and part-time wage and salary employees; data from Bureau of Economic Analysis

types. Figure 2 is illustrative of a key trend within the healthcare sector. The hospital industry entered the 2000s as the largest component of the health care industry, but employment growth has been substantially higher in ambulatory health care services. This group of industries encompasses a range of activities outside of inpatient settings, including the offices of doctors, dentists, and other health care providers; medical laboratories; home health care; diagnostic and imaging centers; and outpatient care centers; among others. Indeed, this local pattern resembles the national trend through which health care has experienced a relative shift away from its traditional concentration within the walls of the hospital. Illinois average annual employment in home health care services, increased by 7% from 2013-2017 (BLS, 2017).

Hospital employment has continued to grow, eclipsing 240,000 in Illinois in 2016, a gain of about 25,000 jobs since 2001. However, as hospitals have consolidated into large healthcare organizations with multiple locations differentiated by the degree of services and specialization, much of the growth has occurred in outpatient settings. According to Bureau of

Labor Statistics data on the Chicago region, about 14,000 jobs were in outpatient care centers⁴, and about 180,000 jobs were in hospitals⁵ in 2017. Although hospitals remain the largest single

industry in terms of employment, most of the growth has shifted toward a significantly broader category of ambulatory care establishments. These local trends reflect a broader pattern identified in recent national studies (e.g., see [Appelbaum and Batt, 2017](#)).

The increasing prominence of large, multifaceted health care organizations in local economies has led to greater recognition for their roles as potential stakeholders in economic and community development beyond the more traditional mission of expanding access to and quality of health care services and improving population-level health. In turn, health care organizations have slowly adopted a broader set of priorities. Along these lines, “anchor institution” strategies hinge on the capacity of large, place-bound organizations to promote economic and community development goals through local hiring and workforce development, local procurement, and community investment

⁴ NAICS code 6214.

⁵ NAICS code 622.

programs. So-called “Eds and Meds” ([Harkavy and Zuckerman, 1999](#); [Bartik and Erickcek, 2007](#)) – hospitals and higher education – represent a major component of the anchor institution landscape; and due to their frequently aggressive expansion programs, broadening the mission of academic medical centers and flagship hospitals to include community development priorities has become a point of emphasis. The Affordable Care Act’s modifications to “Community Health Needs Assessment” and benefit reporting requirements have also brought renewed attention to the important ways that hospitals can improve social and economic health, in addition to providing services ([Zuckerman, 2013](#); [Howard and Norris, 2015](#)). Certainly, this broadened mission also includes converting increasing demand for health care into expanded opportunities for good, stable jobs with career pathways, particularly where disadvantaged places and segments of the workforce stand to benefit. Unfortunately, the historical tension between the role of the hospital as a business enterprise, and as a public service organization has been further complicated by the unevenly distributed pressures of restructuring, reform, and reorganization in the US health care system.

The tension between identities may be creating imbalances. Functioning as a business can obscure the role that hospitals should play in the overall wellbeing of a community. For example, a 2009 Chicago study found that area non-profit hospitals only spent one dollar on charity care for every three dollars they received in tax breaks (O’Donnell, 2009). A 2017 content analysis of Community Health Needs Assessments that all non-profit hospitals are required to file revealed that, “only 9 percent included an explicit activity to promote health equity” (Carroll-Scott, 2017).

FORCES AFFECTING ORGANIZATIONAL RESTRUCTURING AND JOB CREATION IN HOSPITALS

The history of the American hospital has always reflected their dual roles as both businesses and charities ([Stevens, 1999](#)). The modern hospital organization emerged in tandem with the development of scientific medicine and the institutionalization of the medical professions during the late 19th and first half of the 20th century, a period during which medical doctors gained a staggering level of compensation, occupational prestige, and state support over a short period while preserving professional autonomy ([Starr, 1982](#)). However, the sector remained small relative to dominant industries, such as manufacturing and commercial trade. Meanwhile, the federal government’s role in health care gradually expanded – albeit without imposing a strict regulatory influence over the autonomy of doctors and health care organizations – as the postwar health care system grew with the national economy as a whole.⁶ The landmark Medicare and Medicaid legislation in the 1960s expanded access to care for elderly and the poor, respectively, but also provided a windfall that underwrote expansion of the hospital industry. Medicare in particular was a contributor to cost inflation and incentivized investment in high-technology medical interventions and equipment. Starting with Medicare payment reforms in the early 1980s and reaching a crescendo with the Affordable Care Act in the 2010s, federal and state policies have since sought to rein in spending growth.

Illinois Medicaid has recently embarked on cost control initiatives. In July 2012, Illinois Medicaid reduced most rates, including a 3.5% reduction for most payments to hospitals, implementing the Save Medicaid Access and Resources Together

⁶ The federal government began to subsidize hospital construction in the 1940s, and federal policy was also instrumental in the extension and normalization of private

medical insurance as a standard employment benefit through indirect tax code subsidy, beginning the same decade.

Act (Illinois Healthcare and Family Services, 2012). By July 2015, Illinois had moved most of its Medicaid beneficiaries into managed care systems in which most risk of cost increases was transferred from the state to the entity managing care (Smith et al., 2015).

These regulatory measures have combined with a host of technological advancements and financial pressures to foster a profound wave of restructuring in the hospital sector, as health care organizations have coped not only with the tension between market competition and regulatory pressure but also with the moral and economic imperatives of high-tech medical intervention (Kaufman, 2015). Restructuring in the hospital industry is most clearly expressed through two simultaneous processes of ownership consolidation and decentralization (Appelbaum and Batt, 2017; Barr, 2016).

First, hospitals and other health care providers have consolidated into large multi-hospital systems. Many regional markets have come under the dominance of one or two such organizations, which routinely rank among the largest local private employers. For example, in 2018, Chicago-based Advocate Health and Milwaukee-based Aurora merged to create the 10th-largest non-profit hospital system in the country, with 27 hospitals and \$10.7 billion in revenue (Kacik, 2018). Also that year, Ascension Health, the largest non-profit hospital system in the country, acquired Chicago-based Presence Health and immediately integrated into its Chicago-area joint venture Amita Health, which now consists of 19 hospitals with \$4.5 billion in annual revenue (Schorsch, 2018).

Many publicly operated and smaller community hospitals have experienced size reductions and closures or have been swept up in waves of mergers, acquisitions, and reorganizations, even as construction has boomed on the campuses of leading academic medical centers and at the new

hospitals and outpatient clinics of multi-hospital systems vying for regional market share.

The second major trend has been the decentralization of the site of care outside of the hospital to outpatient settings. The reasons for this are multiple, and include both cost-reduction concerns and efforts to expand access to care, e.g., to primary care through patient-centered “medical homes” and to specialized non-emergency services like preventive services, diagnostic imaging centers, urgent care clinics, and outpatient surgery centers. Ongoing cost-containment pressures from Medicare, Medicaid, and private insurance have continued to encourage outpatient treatment, resulting in decreased occupancy rates and shortened hospital stays (Barr, 2016, 91). Yet the “technological imperative” (Fuchs, 1968) continues to coexist with extreme cost-containment measures, and medical bills have continued to climb even as hospitals seek to reduce costs through consolidation and controlling spending in other areas, including labor costs.

With the combination of ownership consolidation and the decentralization of care, hospitals as establishments have increasingly restricted their focus to complex, advanced diagnosis and treatment, but hospitals as organizations have consolidated, grown in size, and diversified in terms of workplaces. This pattern of decentralization could have implications for employees of health care organizations, who presumably would have a broader set of options for having a place of business but a more limited scope for promotions at their current primary employment location. Decentralization also raises the additional possibility for segmenting both low-wage workers and high-earning medical professionals by their location (e.g., large flagship campus versus small satellite clinics). In a recent national analysis, Appelbaum and Batt (2017) find these patterns to be suggestive of an “unraveling of hospital-based employment systems.” The next section examines trends in

hospital employment in the Chicago region and Illinois, with an emphasis on lower-earning hospital service occupations.

THE CHARACTERISTICS OF LOW-WAGE HOSPITAL EMPLOYMENT IN CHICAGO AND ILLINOIS

The evolving processes of regulation, reorganization, and restructuring described in the previous section have consequences for the distribution of cost containment and revenue generation strategies at health care organizations. By reporting the analysis of a five-year sample of households from the American Community Survey, this section illustrates how hospitals in particular continue to depend not only on the specialized health care professions – health care providers, technologists, researchers, and administrators –but also on a large workforce of relatively low-wage service and support occupations. Because the following analysis relies on household surveys and reports five-year averages, estimates of employment levels differ from trends reported earlier in the report, which rely on bureau of economic analysis and bureau of labor statistics data and are based on administrative sources. Additional details on the methods are reported in the appendix.

Table 1 breaks down hospital employment into several occupational categories, using weighted estimates derived from the American Community Survey (ACS). Food service, (e.g., cook, food service attendant, food service worker, dietary service worker, server), maintenance and cleaning (e.g., environmental services tech (EVS), housekeeper, housekeeping assistant, groundskeeper), and healthcare support occupations (patient care tech (PCT), Certified Nursing Assistant (CNA), patient care assistant, medical assistant, orderlies, phlebotomist) combine to account for over 17 percent of total hospital employment in Illinois (about 48,000 workers out of 282,000) and over 16 percent of total hospital employment in the Chicago region (about 33,000 out of 202,000). While demand has increased for these service occupations, wages have largely failed to keep pace (see also Appelbaum and Batt, 2017).

Table 2 reports median wages of hospital workers, broken down by major occupational groups. (These occupational grouping are still quite diverse, and more specific examples are given in the appendix.) The samples are drawn from the most recently available five years of data from the state of Illinois and the Chicago–Joliet–Naperville, IL–IN–WI, Metropolitan Statistical Area (MSA).⁷ The table reveals several interesting findings. First, wages in the Chicago

Table 1: Estimated employment for hospital employees by selected occupational group, Chicago Region and Illinois, 2012-2016 Sample

	Chicago MSA	Illinois
Cleaning and Maintenance	3.4%	3.9%
Food Service	1.8%	2.1%
Healthcare Support	11.0%	11.3%
Social Service	2.0%	1.8%
Health Professionals	43.8%	41.8%
Health Technicians	11.3%	12.4%
Total	73.2%	73.2%

⁷ There is significant overlap between the two samples. The majority of the Chicago MSA population is located within Illinois, and the majority of Illinois' population is located

within the Chicago MSA. The Chicago MSA, however, also includes portions of Indiana and Wisconsin. Current

region tend to be slightly higher than in the Illinois sample, presumably due to differences in cost of living. MSA definitions are determined by the Office of Management and Budget and can be found on the Census Bureau website. Second, health professionals like physicians and registered nurses earn substantially higher hourly wages than middle-income technicians and technologists and social services providers. In turn, hospital service workers earn far less. The estimated median hourly wage is under \$15 for healthcare support occupations and under \$13 for cleaning and maintenance and food preparation and service

occupations. Consequently, we estimate that for Illinois, approximately 29,000-hospital service workers earn below \$15 an hour, and 22,000 earn below \$13. The estimates for Chicago are 18,000 below \$15 and 13,000 below \$13.

Based on these same estimates, and with the caveat that a \$15 threshold is very close to the median worker and thus highly sensitive to measurement issues,⁸ the percentage of hospital service workers earning less than \$15 per hour was 55 in the Chicago region. In Illinois, this percentage increased from 55 to 61 between the

Table 2: Estimated median hourly wages for hospital employees by occupational group, Chicago Region and Illinois, 2012-2016 Sample

	Chicago MSA	Illinois
Cleaning and Maintenance	12.82	12.41
Food Service	12.63	12.12
Healthcare Support	14.92	14.13
Social Service	22.79	23.83
Health Professionals	34.76	33.10
Health Technicians	24.41	22.10

Table 3: Estimated median hourly wages for hospital employees by occupational group, Illinois, 2002-2006 and 2012-2016 Samples

	2002-2006	2012-2016
Cleaning and Maintenance	13.04	12.41
Food Service	12.84	12.12
Healthcare Support	15.06	14.13
Social Service	23.01	23.83
Health Professionals	33.14	33.10
Health Technicians	21.91	22.10

⁸ All survey-based wage analysis suffers from measurement error and sample error, and these issue may be exacerbated

by the wage computation procedure used to generate the estimates presented here. See the appendix for more details

Table 4: Estimated percentage of healthcare service workers earning below \$15 per hour, 2012-2016 samples

	Chicago MSA	Illinois
Cleaning and food service*	63%	70%
Healthcare Support	51%	57%

*Due to a smaller sample size and similar estimated wage levels, Food Service and Cleaning and Maintenance Workers have been combined for this tabulation

2002-2006 and 2012-2016 samples (Table 3). Table 4 shows that the estimated percentage earning less than \$15 per hour is higher for food service and cleaning and maintenance workers than for healthcare support occupations.

Earning so little creates a myriad of economic challenges for employees. Chicago-area hospital support workers report living on the edge of solvency. A 15-year male Northwestern Hospital employee expressed this tenuousness simply by saying he is forced to “live from check to check.” An environmental services tech at Presence

Resurrection Hospital elaborates: “It’s a pay check to pay check situation. I sometimes don’t have enough for rent, food, or for my bus card to get to and from work.” A Norwegian American Hospital worker being paid \$13.50 recounts how on a “month to month basis I have to sit and look at the calendar to check due dates and make decisions on what [bill] to pay first.” Another 13-year female worker from Ingalls shares that she has “to work two jobs and I’m overworked and underpaid. I don’t see my hard work in my pay check at all.” Earning only \$10.40 an hour, a transporter (i.e., move patients around the hospital) at Ingalls laments, “I am barely above water and I can’t afford rent anywhere in the country.” Too often workers have to make untenable choices unimaginable by hospital administrators. “I sacrifice bills, choose which bills to pay,” claims a female unit assistant at Swedish Covenant Hospital who earns \$12.70 per hour. Her choice is a devastating one: “I have to

choose between food and childcare.” The dilemma of being working poor strains the line between sickness and health. A Resurrection technician’s \$12.69 per hour payment means that, “Sometimes I can’t even afford going to the doctor because I don’t have the \$50 for my copayment.”

Often the hospital rate of pay needs to be subsidized by others. At \$10.59, an Ingalls Hospital employee has to “rely on help from others to make ends meet.” An \$11 an hour female employee at Presence Resurrection Hospital reveals that to feed her child she has “to go beg grandma for something.” Another Resurrection employee offers that he sometimes has to visit a “nearby food pantry and to try and do the max with they give me.” A Franciscan St. James Hospital patient care tech “relies on Medicaid because the insurance is too expensive” at her job. All of these people are working fulltime and work does not pay. The private non-profit hospitals are all essentially relying on the charity of others to supplement the minimal amount that they pay their service employees.

However, depending on the good will of friends is a slender prop for insufficient wages. A single mother who works for \$12.79 at Franciscan Olympia Fields Hospital admits that she “almost lost [her] home twice.” At the time, her son was on a dialysis machine. Incredibly, she could not afford the hospital’s insurance.

The meagre wage not only affects the economic conditions of the employees. A patient escort at Northwestern reveals that her “duties keep getting added” to the job, the low pay “makes it difficult to provide the positive experience they [the patient] deserve.” A 13-year certified nurse assistant at Ingalls complains, “I don’t see my hard work in my paycheck.” Research on work motivation has documented that workers, who

believe their work is not appreciated show reduced loyalty to their employer.

Making only \$12.83 after 18 years of service also means enduring other painful sacrifices. “My biggest sacrifice is time with my family,” said a Latina employee at Resurrection. “The entire time of me working at the hospital I’ve had to work and extra day a week to be able to pay my bills and stay afloat.”

Tables 5 and 6 illustrate how the demographics of Illinois hospital service workers have changed over time and how they compare with the demographics of all employed workers in the state. Women are sharply over-represented among hospital service workers, although this share appears to have experienced a slight decline. This is not surprising, since many of the occupations

that fall under the umbrella of the healthcare support occupational group – the largest component of healthcare support occupations in hospitals– have traditionally been dominated by female workers. Additionally, in Illinois “women of color” make up roughly 10,450 of all hospital service employees.

Table 6 breaks down hospital service workers into major racial categories and Hispanic origin (a proxy for Latinx background) for hospital service workers and for workers in the economy as a whole. Hospital service workers are less likely to be white than the workforce as a whole; and although black workers are over-represented in hospital services employment, both black and white workers have seen their shares decline. Meanwhile, the share of Hispanic workers has increased. Table 7 presents similar breakdowns

Table 5: Demographics of hospital service workers in Illinois, 2002-2006 and 2012-2016 samples

		2002-2006	2012-2016
Female %	Hospital Service	79	76
	All Employees	47	49
Median Age	Hospital Service	42	39
	All Employees	39	40
Assoc. Degree or higher %	Hospital Service	17	26
	All Employees	43	49

Note: Educational attainment is for workers age 25 or older

Table 6: Race and Hispanic identification of hospital service workers in Illinois, 2002-2006 and 2012-2016 samples

		2002-2006	2012-2016
White alone %	Hospital Service	56	50
	All Employees	69	65
Black alone %	Hospital Service	30	25
	All Employees	11	12
Asian/PI alone %	Hospital Service	3	6
	All Employees	4	5
Hispanic %	Hospital Service	7	14
	All Employees	11	13
Other %	Hospital Service	4	5
	All Employees	4	5

Note: To simplify race and ethnicity categories, White, Asian/Pacific Islander, Black/African American are determined by race alone. Hispanics of all races have been classified as Hispanic. “Other” includes any other racial categories and those who identify with two or more races.

Table 7: Race and Hispanic identification of hospital service workers in Chicago MSA, 2012-2016 samples

		2012-2016
White alone %	Hospital Service	36
	All Employees	57
Black alone %	Hospital Service	31
	All Employees	14
Asian/PI alone %	Hospital Service	8
	All Employees	6
Hispanic %	Hospital Service	19
	All Employees	17
Other %	Hospital Service	6
	All Employees	6

Note: To simplify race and ethnicity categories, White, Asian/Pacific Islander, Black/African American are determined by race alone. Hispanics of all races have been classified as Hispanic. "Other" includes any other racial categories and those who identify with two or more races.

for the Chicago region for 2012–2016 and shows similar patterns relative to the entire regional economy. The Chicago region's workforce, however, is more diverse than the state's as a whole. Thus, people of color represent a strong majority of the hospital service workforce in the region, compared with roughly half statewide.

The over-representation of people of color and women in relatively low-wage hospital service employment replicates society-wide patterns of employment inequality within the hospital setting. Moreover, as shown in Table 5, educational attainment levels have actually been increasing among hospital service workers at a rate faster than the total population of employed workers.

Using similar national data, Appelbaum and Batt (2017) find that real median earnings were relatively "stagnant" for health care workers between 2005 and 2015. Hospital workers experienced a very modest increase in wages at the median; and in some cases, earnings gaps correlated with gender, race, and ethnicity narrowed, although gender wage gaps remain substantial. At the same time, median real wages actually declined for workers in outpatient care centers, a troubling finding in light of the gradual but general shift of routine care from hospitals to smaller, decentralized sites. Changing workforce composition, such as declining average skill-levels over time, could explain the pattern of

stagnant wages. However, Appelbaum and Batt (2017) reject this explanation and actually find that educational attainment levels have increased over time.

CONCLUSION & RECOMMENDATIONS

The health care sector is marked by uneven development. The federal government spends more on Medicare and Medicaid than on defense or Social Security, but federal regulations and cost-containment measures have prompted a protracted and chaotic period of restructuring. Health care is considered to be a primarily locally serving industry, yet its importance to local economies as an employment generator and putative source of upward mobility has, to an extent, replaced that of traded industries, like manufacturing. Declining occupancy rates, system consolidation, and the rise of outpatient care has reduced services and caused closures of community hospitals in inner cities, inner-ring suburbs, and rural areas. Meanwhile, construction is booming in outpatient facilities, wealthy suburbs, and on the ever-expanding campuses of system flagship hospitals and academic medical centers.

As in nearly every state and region in the United States, the healthcare sector has become an important economic driver in the Chicago region and in the state of Illinois. Throughout the long cycle of declining employment levels in traditional industries like manufacturing and the shorter cycles of recession and recovery since 2000, health care has continued to add jobs. Hospital organizations continue to occupy the focal point of the health care system, but a mix of regulatory and cost-based pressures and incentives have driven a profound and uneven process of restructuring in the industry. Ownership has consolidated into multi-hospital systems even as care has decentralized outside of hospital walls, and some hospitals have closed or restricted services as others have experienced sizable investments in construction, reorganization, and technology.

Hospitals have the potential to fill a crucial hole left by an increasingly bifurcated labor market. In practice, however, wages have been stagnant despite increasing demand for workers. This report focuses on workers in Illinois and the Chicago region who are employed in hospital services position, defined here as healthcare support occupations, food preparation and service occupations, and cleaning and maintenance occupations. As a whole, the evidence suggests that the dramatic growth of the health care system and prolonged processes of organizational restructuring and cost-containment have not led to investments in the non-professional hospital workforce. While the hospital landscape has been in a decades-long state of upheaval, it is also increasingly dominated by large organizations. A broad constituency of community leaders, organizational leadership and healthcare system stakeholders should begin to embrace a broader mission for healthcare organizations as major economic stakeholders in their communities. In that endeavor, three steps to address the low wage nature of hospital service workers are recommended.

First, healthcare organizations need to improve the compensation standards of hospital service workers in order to raise their wages above \$15. A proven and robust predictor of higher wages is unionization. Studies of union impacts on hospitals wages have consistently found positive wage effects typically ranging from 3 to 12 percent (Coombs, 2015; Hirsch and Schumacher, 1998; Salkever, 1982; Becker, 1979; Fottler, 1977). Policy and legal measures that protect workers' rights to organize are powerful tools for advancing the incomes of both professional and nonprofessional healthcare occupations.

Hospitals are powerful place-based "anchor institutions" that have an obligation and incentive to invest in their local communities. As described in the report *Can Hospitals Heal America's Communities: "All in for Mission" in the Emerging Model for Impact*, "anchor institutions are enterprises such as hospitals and universities that are rooted in their local communities by mission, invested capital or relationships to customers, employees, and vendors. Anchor institutions possess considerable human and economic resources that can be leveraged for local development, particularly to improve the well-being of low-income children, families, and neighborhoods that are often proximate to their campuses." However, despite its promise, the increasingly accepted vision for anchor institutions places too little emphasis on the responsibility of large healthcare organizations to support a livable, sustainable wage among their own employees. Chicago hospitals are relying on thousands of low wage workers to provide critical services in a chain of healthcare delivery that reaches thousands of people every day and generates millions of dollars in corporate revenues. As the report stresses, "anchor mission means that a place-based institution consciously applies its considerable resources toward improving the long-term well-being of its community." Surely paying service employees

who live in the community a livable wage is consistent with the mission.

Additionally, open pathways to career advancement within the healthcare sector should be provided. To maximize employee welfare gain and distributional equity, investments in hospital-based economic development should be accompanied by strategic attention to workforce training and “career ladder” development. Most career-ladder programs are partnerships involving government workforce-development agencies and some combination of community colleges, unions, community organizations, and employers. Advancement opportunities for workers, along with reasonable compensation levels represents a genuine investment in worker-advancement systems.

These measures would allow hospitals to embrace their potential as not only job engines but as mission-driven organizations that mitigate – rather than exacerbate – the bifurcation of employment opportunity.

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APPENDIX

Occupational and Industry Categories

The broadest category for the health care sector is 62 “Health Care and Social Assistance” according to the North American Industry Classification System (NAICS) hierarchy, which includes Ambulatory Health Care Services, Hospitals, Nursing and Residential Care Facilities, and Social Assistance. Analysts often consider only subsets of this broad sector as “the health care industry,” e.g., social assistance is routinely dropped. Moreover, other industries are often combined above the two-digit level. It is only at the two-digit level that health care has surpassed other industries in size.

Except where noted elsewhere in this report, “health care” workers are limited to those employed in the following industries:

- 622 Hospitals
- 6214 Outpatient care centers
- 6211 Offices of physicians
- 6213 Home health care services
- 6231 Nursing care facilities

Occupations are similarly determined by the Standard Occupational Classification system (SOC codes). Occupational groups and example occupations examined in this report nearly replicate the codings in Appelbaum and Batt (2017), although the definitions are not exactly identical, and are defined as follows:

- 31-0000 “Healthcare Support”: Nursing, psychiatric, and home health aides; Orderlies; Medical Assistants; Pharmacy Aides; Phlebotomists; other healthcare support workers.
- 35-0000 “Food Preparation and Service”: Supervisors of food prep and serving workers; chefs and cooks; Food preparation workers; Waiters and Waitresses; Nonrestaurant food servers.
- 37-0000 “Building and Grounds Cleaning and Maintenance”: Supervisors; Janitors and Cleaners, Grounds maintenance, Landscaping and groundskeeping.
- 29-1000 “Health professionals”: Pharmacists; Physicians and Surgeons; Physician assistants; Registered nurses; Therapists; Nurse anesthetists, midwives, and practitioners.
- 29-2000 and 29-9000 “Health Technologists and Technicians”: Clinical Laboratory Technologists and Technicians; Health Practitioner Support Technologists and Technicians; Licensed Practical and Licensed Vocational Nurses; Other Healthcare Practitioners and Technical Occupations
- 21-1000 “Counselors, Social Workers, and Other Community and Social Service Specialists”: Healthcare Social Workers; Mental Health and Substance Abuse Social Workers; Health Educators; Community Health Workers.

In this report and following the precedent in National Employment Law Project (2017), “Hospital service workers” are defined as the first three occupational groups listed above: Healthcare support, Food preparation and service, and Building and grounds keeping and maintenance.

Additional information on relevant SOC codes is available in Appelbaum and Batt (2017) and at the Bureau of Labor Statistics website.

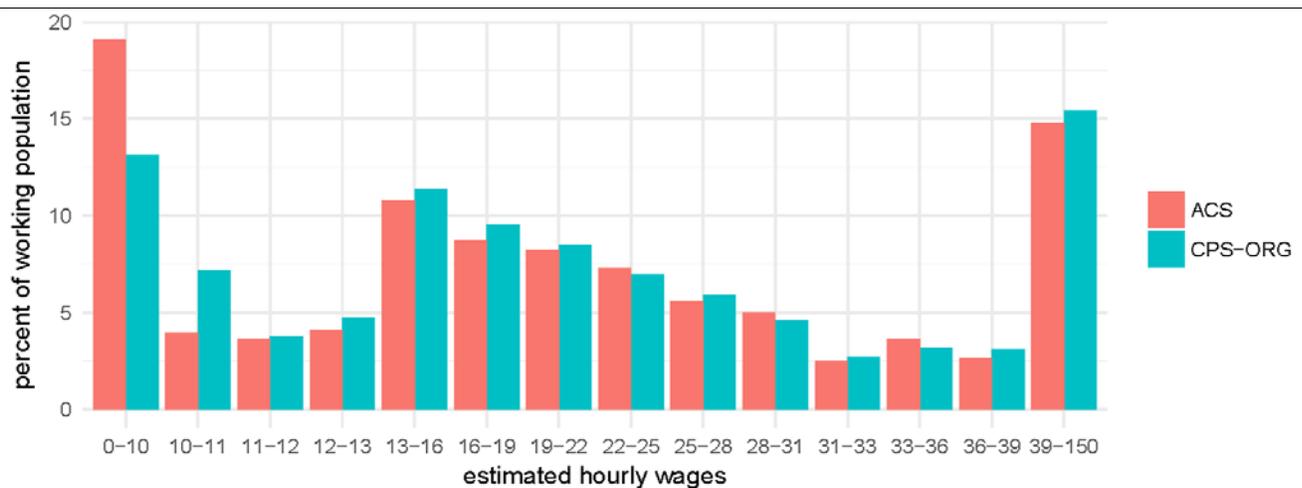
Data Sources and Analysis

This analysis takes cues from two recent studies by the National Employment Law Project (2017) and Center for Economic and Policy Research (Appelbaum and Batt, 2017). There are some significance differences, primarily due to the local nature of the present study. For example, the data sources are different and, in some instances, only data for Illinois are reported because the sample size is larger for the time periods in question.

The NELP analysis was based on CPS-ORG data, which has the advantage of including wage information. However, the sample size is too small to reliably support the analysis of detailed occupations or occupations within industries at the heart of the present study. As a result, the present study relies on the much larger sample size available with ACS microdata. This source, however, does not include an hourly wage question and thus requires a computed estimate of hourly wages based on three fields: weeks worked per year, usual hours worked, and wage and salary income. Following the design of the ACS, this income measure includes wages, salaries, commissions, cash bonuses, tips, and other money income received from an employer but excludes payments-in-kind or reimbursements for business expenses. As the weeks worked last year measure is provided as an interval, we recode its value as the midpoint of each interval. Hourly wage is estimated by dividing annual wage and salary income by the product of weeks worked and usual hours worked. Finally, estimated wages below \$1 and above \$150 are dropped from the analysis to remove noise and outliers. This step follows the practice used in the methodology of numerous previous reports (see, e.g., Perry et al., 2016, 3).

Since the ACS wage is computed, the wage distribution varies somewhat from the wage distribution in the CPS-ORG. Figure 3 illustrates an estimated wage distribution for all Illinois workers using two different data sources: the ACS extract from IPUMS used in the main body of the report (Ruggles et al., 2017) and the CPS-ORG extract published by CEPR, also used in (National Employment Law Project, 2017; Appelbaum and Batt, 2017). While these two data sets differ in terms of how wages are quantified—or computed from annual earnings in the ACS case, the distributions are fairly similar, with the exception of hourly wages of \$11 per hour or lower. The difference is likely an artifact of the hourly wage

Figure 3: Comparison of estimated wage distributions from ACS and CPS-ORG, state of Illinois, 2012-2016



Note: ACS wage estimates are derived from a computed procedure. Both wage estimates include wages, tips, and overtime. Both samples include wage and salary employees aged 16-64 in Illinois (i.e., self-employed workers and individuals who are not employed are not included).

computation procedure, which may bias low wages further downward. However, it is unlikely that this issue dramatically affects estimates at and around the median, as reported above.

In addition to the computed wage estimates, income estimates of income from wages and salaries during the previous twelve months are provided below in Tables 8 and 9. These are based on more direct (i.e., less extrapolated) measures in the underlying ACS data.

Table 8: Estimated median annual wage and salary income for hospital employees by occupational group, Chicago, 2012-2016 sample

	Full-time
Cleaning and Maintenance	28,000
Food Service	26,153
Healthcare Support	30,908
Social Service	49,706
Health Professionals	71,009
Health Technicians	50,648
All workers	50,648

Table 9: Estimated median annual wage and salary income for hospital employees by occupational group, Illinois, 2012-2016 sample

	Full-time
Cleaning and Maintenance	25,418
Food Service	26,153
Healthcare Support	30,908
Social Service	49,706
Health Professionals	67,997
Health Technicians	46,515
All workers	48,035

For the purposes of these estimates, “full-time” is defined as working 35 or more hours, and “full-year” is defined as working 50 or more weeks (see Table 10 below).

Table 10: Estimated hours for hospital services workers, Illinois, 2012-2016 sample

	Hospital Services	All Employees
< 25 hours	25,418	24,994
25 - 35 hours	26,153	24,017
> 35 hours	30,908	28,229

Having examined several sources of data, we note the discrepancies across estimates of hospital employment derived from different sources. The bulk of the analysis in this report, including every table, is derived from the ACS as described above. Household surveys like the ACS and CPS-ORG have the advantage of enabling more detailed breakdowns by occupation and demographic characteristics. However, Figures 1 and 2 are derived from Bureau of Economic Analysis (BEA) data, and Bureau of Labor Statistics (BLS) data is also used as noted in the body of the report. The BEA and BLS are not identical but are similar in that they report estimates of jobs as derived from the analysis of administrative data, like data collected for unemployment insurance programs. These data are more readily and widely used for employment trends. In contrast, as a household survey, the ACS-based estimates count employment in terms of workers who are classified according to their primary job. The natural discrepancy between job-based and worker-based employment estimates is likely further complicated

by the fact that hospitals are large, complex organizations characterized by work relationships that may not be accurately captured in conventional data sources. For example, doctors who primarily work with a single hospital system often display a variety of employment and self-employment statuses that may lead to miscoding in both UI-based and survey-based estimates. In addition, some support workers who primarily work on a hospital campus may do so through a contracted services company (e.g., parking or janitorial services), a situation that could also contribute to industry miscoding. As a result, we urge caution in interpreting estimates of employment levels.

In addition to the data analysis, we examined 55 written personal narratives of hospital service workers. These worker accounts were drawn on to add depth to the implications of the administrative data. With near unanimity workers expressed similar difficulties with managing their life while earning low wages. Employee's years of work in the industry ranged from 11 months to 37 years. The mean years of employment was 12.4. These stories were collected by the Service Employees International Union Healthcare Illinois, Indiana, Missouri, and Kansas from employees in Chicago area hospitals. The hospitals represented are listed below in Table 11.

Table 11: Hospitals represented in personal narratives

Presence Resurrection
Franciscan St. James
Norwegian American
St. Bernard
Northwestern Medical
Ingalls
Swedish Covenant
Franciscan Olympia Fields
Methodist
Adventist
St. Mary's
Schwab Rehabilitation
University of Illinois at Chicago
