Episode: Ethics Talk Videocast Transcript – Plight of Workers in Low Wage Jobs and COVID-19

Guests: Donald Tomaskovic-Devey, PhD
Host: Tim Hoff; Audiey Kao, MD, PhD
Transcript by: Cheryl Green

Access the video and podcast **here**

[bright theme music]

TIM HOFF: Welcome to another special edition of *Ethics Talk*, the *American Medical Association Journal of Ethics* podcast on ethics in health and health care. I'm your host, Tim Hoff. This episode is an audio version of a video interview conducted by the Journal's editor in chief, Dr Audiey Kao, with Dr Donald Tomaskovic-Devey. Dr Tomaskovic-Devey is the Executive Director of the Center for Employment Equity at University of Massachusetts Amherst. He joined us to talk about the social and economic hurdles confronted by those among us in low-wage jobs during the COVID-19 pandemic. To watch the full video interview, head our site, JournalofEthics.org, or visit our YouTube channel.

DR AUDIEY KAO: Hello, Professor Tomaskovic-Devey. Thank you for being a guest on *Ethics Talk* today.

DR DONALD TOMASKOVIC-DEVEY: Hey there, Audiey. It's my pleasure. Thanks for inviting me along.

KAO: So, according to U.S. labor statistics, 40 percent of workers earn less than $15/hour. It's my understanding that there is no consensus on how low-wage work is defined. So first, how do you define low-wage jobs? And then secondly, how has the economic disruption caused by this pandemic affected the livelihood of workers in low-wage positions, many of whom are considered essential workers in this pandemic?

TOMASKOVIC-DEVEY: Great questions. The definition of low-wage work is something that we as a society have to come to grips with. In a legislative sense, we have a national minimum wage of $7.65/hour, which is not a living wage, even for a single individual, in any state in this country.

KAO: Right.

TOMASKOVIC-DEVEY: There's been a social movement, the Fight for 15, that's argued that $15/hour would be a more appropriate minimum wage. And in many parts of the country, that actually would be a living wage that even a family with two adult workers and two children could live on. I live in Massachusetts, and it would not be a living wage in Massachusetts.

KAO: Right.

TOMASKOVIC-DEVEY: A family of workers with two children would still need over $20/hour. And one of the things that I think in a kind of a moral sense at the societal level is we need a national minimum wage of $15/hour, and then we need local variations to adjust for local standards of living. And it should be indexed for inflation.

KAO: Yeah.

TOMASKOVIC-DEVEY: And the current minimum wage in Massachusetts is a little bit over $12/hour, which is what the national minimum wage was worth in 1968. So, right now Massachusetts seems like a progressive state, but it's no more progressive than the whole country was back in 1968. And so, indexing minimum wage for inflation is a really, really important way as a society to realize that the people who are low-wage also are [audio drops]. And if you don't build the power into the system that it automatically adjusts wages, they're going to fall behind again.

KAO: Yeah.

TOMASKOVIC-DEVEY: The second part of your question, which goes towards the what's happened to low-wage workers during the COVID pandemic, I think many of us recognize that the unemployment rate and the people who've just lost jobs from the various shutdowns have been disproportionately people in low-wage jobs. And that has multiple dimensions to it. It's obviously, for that population, these are the people with the lowest level of resources to cope with lost wages. Part of the disproportionality is that employers tend to keep their managerial and professional workforce and not lay them off. There's also the issue of the capacity to work from home. But then there's also low-wage industries are some of the ones that've been most hard hit. So, that's one dimension of it. Probably the unemployment rate's 21 percent now. It'll probably keep going up for the next month or two. Even right now, the Federal Reserve estimates that 30 percent of workers in the U.S. in April were either unemployed or underemployed. That is, they wanted to work more hours, which is just terrific. That's a third of the country.

KAO: Yeah.

TOMASKOVIC-DEVEY: The flip side is that it's also low-wage workers who have been disproportionately among the essential workers who actually are going to work. So, then you have the kind of health risks associated with that.

KAO: Sure.

TOMASKOVIC-DEVEY: And there, we've just actually finished a survey. We're finding 90 percent of people, the essential workers who are still at work, are saying that the kind of the stress of going to work is very high. Many don't feel safe at work; 60 percent report feeling unsafe at work. And these are mostly people who are directly working with customers of one sort or another. Those numbers are pretty much the same for health care workers, by the way.

KAO: So, if I can follow up on that, one of the other, besides social distancing, one of the other key pieces of advice offered by public health experts during this pandemic is if you feel sick, stay home.

TOMASKOVIC-DEVEY: Right.

KAO: Well, more than 90 percent of U.S. workers in the top quarter of earnings have paid sick leave. Only about 50 percent of workers earning wages in the lowest quarter—so, about $14 an hour—have it. In response to the coronavirus pandemic, Congress enacted emergency legislation to temporarily give many Americans access to paid leave. That said, it's my understanding that the U.S. and South Korea are the only two OECD countries

where paid sick leave is not guaranteed for all workers. So, what are the barriers for achieving universal paid sick leave in the U.S., and how can we overcome them?

TOMASKOVIC-DEVEY: That is a really big question. And it's partly that the U.S. is an outlier on many dimensions in terms of the social welfare systems and the institutions that protect workers. There are some states that have paid sick leave. Massachusetts is one of them. California is another. But they work a lot like unemployment insurance in that you have to work so many days to accrue so many hours of paid sick leave. And they have maximums. And Massachusetts is actually the most generous, and it's 40 hours. So, that basically means you get one week of paid sick leave after at least a year of work.

KAO: Mmhmm.

TOMASKOVIC-DEVEY: We can see how this doesn't fit at all the path of this disease.

KAO: Yeah.

TOMASKOVIC-DEVEY: And so, that's a problem. And I think that the larger answer to your question is we have to reform our institutions, and paid sick leave is one of them. I think we could say something very similar about family paid sick leave, not just the individual paid sick leave.

KAO: Right.

TOMASKOVIC-DEVEY: We can say this about our health insurance system. We could say this about a lot of things. Unemployment insurance in the U.S. tends to cover, depending on what state you're in, between 30 and 40 percent of lost wages. In most OECD countries, it's between 60 and 70 percent. So, we have a social welfare system that assumes people are going to get what they need to support their families from their jobs. And that's not just the wage; it's also things like health insurance. So, we actually have to move away from an employment-based system to a citizenship-based system. And that's going to take some serious work. Work we're doing now at the Center, we talk about it as we need a new New Deal. American social welfare system was born out of the New Deal in the '30s, and it was tied strongly to work. It also eliminated or tried to have exemptions for jobs with strong African-American presence, that it was both a racist system, and it was a system that prioritized employment. And that's become a disaster over time. It wasn't so bad when we had strong unions and when, in the '50s and '60s, where American firms didn't face much international competition, where the health care system was decentralized. Increasingly, this is just a terrible system. It puts burdens on employers, and the employers find ways to get out of it.

KAO: Yeah.

TOMASKOVIC-DEVEY: I mean, even in our work on essential workers during the COVID crisis, we find that even in the health care industry where most people— Our survey's in Massachusetts. So, Massachusetts, 97 percent of people have health insurance. We've got the best coverage rate in the country. But 10 percent of low-wage health care workers in Massachusetts don't have health insurance, and most are the ones who do, they don't get it through their employer. They get it through the social welfare system.

KAO: Right.

TOMASKOVIC-DEVEY: I really think we need a Medicare for All system.

KAO: If I can follow up on some things you said earlier. As you know, we are seeing disproportionate health impacts of COVID-19 among minority communities. And as you alluded to a few moments ago, people of color are more likely to be workers in low-wage positions. These workers are also more likely to live in large households and have an older adult living in the house with them. And we just mentioned the issues of lack of health insurance coverage, and that share of people lacking in coverage is likely to go up amid the economic downturn. So, since people in low-wage positions need to work despite the risks of contracting COVID-19, many advocate for hazard pay. So, what are your thoughts about whether and how to provide hazard pay in this situation?

TOMASKOVIC-DEVEY: Certainly, these jobs were stressful and disrespectful jobs before the COVID-19, and now COVID-19 makes us as a society realize, oh, the workers we thought were disposable are actually essential, right?

KAO: Yeah.

TOMASKOVIC-DEVEY: And suddenly, we become more generous and think, what can we do? Should we compensate? It's obviously also a union strategy, the idea of hazard pay, so where people are unionized. I totally think giving stressed households more income during this crisis, whether it's paid for by the employer or paid for by the state, is a really good idea. From an ethical point of view, I don't see how it's any fairer now than it would be in the absence of a crisis. That is, those jobs should've been being paid more, and we should've had universal access to health insurance and paid sick leave and the like. And these are social choices. They're social choices that happen over very long periods of time, and they're path-dependent on the decisions in the 1930s and the like. But the United States is a total outlier on these issues. You said something about Korea, but Korea has universal health insurance and single payer, has a strong insurance system. Korea is one of the weaker OECD countries for other types of welfare supports, household support, but nobody's as weak as the United States.

KAO: Yeah. So, if I can pivot a little bit and focus on those among us in low-wage positions in the health care industry. So, according to a Kaiser Family Foundation study, 3.5 million Americans in low-wage positions—and in this study, they define that as being the bottom 20 percent of earners among working non-elderly adults—are in the quote-unquote "health and social services" industry.

TOMASKOVIC-DEVEY: Uh-huh.

KAO: And the greatest number of those, about 1.3 million, work as aides, such as nursing assistants, whose jobs bring them into frequent close contact with patients. And nearly a million more work as direct-contact support workers such as janitors or those in food services whose jobs also will bring them into direct contact with others. Since it takes a village, so to speak, to care for patients in the hospital, what obligations do workers in high-wage positions have to promote the financial well-being of their health care team members earning low wages? And if there are such obligations, how should they be exercised?

TOMASKOVIC-DEVEY: It's a great question, and it's a moral question. And...and it's a hard question. So, I'm a social scientist. And I typically will approach a moral question from the lens of what is a current set of social relationships, and what could we envision might

be a different set? It's hard to have a moral principle that's, for me, that's outside of that. And in general, I mean—so, I'm going to sort of back up and say something that's pretty abstract—in general, when human beings decide to share or to cooperate, they're more likely to do it with somebody that's like them, with their ingroup. In the U.S., we often talk about race, sometimes about gender in this way, but this is also very true about kind of skill differences, class differences, status differences. And if you're looking for a moral frontier about people that could be ignored or exploited or excluded, this low-wage work, low-skill work versus high-wage work, high-skill work is one of those moral frontiers. And the health care industry is built around, kind of the original infrastructure, around the professionalization of skilled workers: of doctors, nurses, some categories of nurses. And so, that kind of status hierarchy is built into the system.

KAO: Yeah.

TOMASKOVIC-DEVEY: And so, you'd actually need to reduce that moral distinction of deservedness and undeservedness to get that, to get to a new social space.

I actually think that there is an opportunity here, because something has changed in health care from its origins, which is it's now we increasingly see that the health care industry is concentrated in fewer and fewer firms, often firms that are not even based in health care. You've got a lot of private equity now buying up hospitals and creating kind of these large health care combines. Similarly, obviously, this has happened in the insurance side. Those types of ownership structures put tremendous downward pressures on labor costs at both the professional levels and the workers' levels. So, we've seen for, especially among nurses, kind of this union-based movement to connect care to staffing. We've seen among doctors kind of the movement to kind of professional groups that are outside of those big corporations as a sort of a means of protection from them. So, perhaps there's room for solidarity because there's a new, stronger status hierarchy that's eating up the system.

KAO: Increasingly more physicians are employees of large hospital systems. And speaking of hospitals, it's my understanding that the Department of Health and Human Services has dispersed at least $70 billion in grants since April, with plans to distribute $100 billion dollars more to hospitals and other health care providers through the CARES Act. It's been reported that 20 large hospital systems have received a total of more than $5 billion in recent weeks. These hospital systems, with many established as non-profits, have more than $100 billion in cash, according to regulatory filings and bond rating firms. By comparison, hospitals that serve low-income patients often have only enough cash on hand to finance a few weeks of their operations. So far, hospitals that serve greater proportions of wealthier, privately-insured patients have received twice as much relief as those focused on low-income patients with Medicaid or no coverage at all. So, what should be done in the near term to address this disparity in relief funding? And then in the long run, how should we expect financially-secure hospitals, especially those that are non-profits, to treat workers in low-wage positions just as importantly as frontline clinicians in keeping the health care system functioning?

TOMASKOVIC-DEVEY: Yeah. So, there's two kinds of questions there. One is the really sticky one, is how does one distribute money fast in a crisis, right, when you don't have a playbook? And so, what happened in terms of the money going to the better-off hospitals happened throughout the whole economy, the kinds of firms that were able, that had the capacity to mobilize faster got the money faster. There seems to have also been some collusion between the banks that were distributing the money and what they saw as their stronger partners. So, we've seen that. That seems to be a problem in this system. I'm not

sure I have a good answer as to how it could've been prevented or clawed back. The odds are that the application process was too complex.

But it's also, if you're a rich organization, you're going to have more people in the organizations whose job it is to respond to opportunities. And a stressed organization is not going to have this. So, this has been true in the small business field where the big small businesses got all the money. So, this is a problem in the health care system between poor- and minority-serving hospitals, rural hospitals, small independents versus this kind of this large corporate hospital systems. And I think right now our health care system is set up as a money-making device for organizations that are big enough to be able to create local monopolies. And we've been talking about pharmaceuticals and insurance like this for decades now. It's increasingly the case in the way hospitals are organized. Before, I said that at the level of households, we really need a Medicare for All. If you go towards, let's say if you move towards a single-payer system, the power associated with monopolies goes away.

KAO: So, if we move beyond the hospital or inpatient care setting, a study found that nearly 2.3 million homecare workers in the U.S. receive a median wage of about $11/hour and earn about $16,000 annually. That means that more than half of homecare workers rely on some form of public assistance. And nearly nine out of 10 homecare workers are women, about two thirds are people of color, and then about a third are immigrants. This seems to represent another example of privatizing benefits and socializing costs. What should and can be done to address this matter in your opinion?

TOMASKOVIC-DEVEY: Yeah, I think that I like that you've used this phrase, "privatizing benefits and socializing costs." And this runs right throughout the U.S. economy. Low-wage workers depend on the state for their health insurance. They often have food supplements, often are using food banks and have a variety of kinds of short- and long-term stressors. And I think that once that this has been the case, it's sort of tied to the kind of way we provide services in the society. And it does help kind of illustrate the issue of who's responsible.

So, I mentioned before in our survey in health care workers, only about 25 percent of health care workers, low-wage health care workers, were getting their health insurance through work.

KAO: Hmm.

TOMASKOVIC-DEVEY: Most of them were either didn't have it or the big group getting it through the state. So, exactly what you're talking about here. Even though the higher-wage people in the same building were getting it through the hospital, getting it through their employer. So, it is an equity. And once you start thinking about it in organizational terms, it's an inequity that happens with the people we're working with.

Now, I think at the very beginning of the conversation, we pointed to solutions, which is you need to somehow strengthen, in an institutional sense, those citizenship rights. So, Denmark, I love to talk about Denmark partly because in February, Denmark had an unemployment rate of 3.5 percent, just like the U.S. And across the COVID pandemic, it went up to 5.1 percent, and we're up around 20 percent. And that's because they kept people employed, right.

KAO: Mm.

TOMASKOVIC-DEVEY: In Denmark, everyone has rights to family medical leave, to sick pay. It's a single-payer universal health care system, and the minimum wage is $22/hour. That solves all of these problems.

KAO: Yeah.

TOMASKOVIC-DEVEY: And in some ways, our system was set up in a period of class struggle. And the solutions in the '30s were, let's make employers responsible, right? And when unions were strong, that actually worked pretty well, though it never worked very well for minority workers. But the class struggle didn't end, and employers have found ways to cut costs and to externalize. So, in many of your hospitals, some of those support workers at least, are going to be working for different firms. They'll be employed through some subcontract firm that provides cleaning services or cafeteria services or the like. Home health care workers, it's all subcontracted firms, or just about. You know, there are some state workers somewhere, in some places. And so, the class struggle in that sense is we have a welfare system that tells employers it's their responsibilities to pay for this. And then employers do what employers do. They figure out a way to cut costs. You have to take, I mean, clearly, in the 1930s, these were big gains, but it's a ridiculous way to set up a rich society.

KAO: Yeah.

TOMASKOVIC-DEVEY: It's a society that throws people away.

KAO: Yeah. So, I'd like to end our conversation today by getting your thoughts. You mentioned just a moment ago about the history and power of unions in the U.S. And we also talked about, a few moments back, about physicians who are now increasingly employees. And health care workers have pioneered a new form of social justice unionism, which declares that their working conditions are their patients healing conditions. So, what do you think it will take to get us to a point where people are not viewed, in your words, as disposable, and we accomplish and create a system where there is a living wage and that people are supported?

TOMASKOVIC-DEVEY: Yeah. Well, that requires probably social movements that outlast this COVID-19 moment. On the other hand, the COVID-19 moment has empowered essential workers, and we do see wildcat strikes going on across the United States. A lot of it's in manufacturing and health care. And before, you talked about hazard pay. Where you see hazard pay, it's either that the firm has come under big public relations pressure for doing bad, let's say, like Amazon, or there's been local pressure from a union. And so, we do find that low-wage workers are getting hazard pay, especially in grocery stores. That's partly people don't want to come to work.

KAO: Yeah.

TOMASKOVIC-DEVEY: Right? Because it is scary to come to work. But anyway, these are things that can be built on. Now, the problem is you need some set of, you need some organization to keep it alive beyond people's moments of being scared. Unions are really important there. Again, you brought up the OECD before. In most high-income countries, doctors are unionized.

KAO: Yeah.

TOMASKOVIC-DEVEY: The United States is an exception. Now, on the other hand, doctors' pay in the U.S. is often high relative to other parts of the world, partly because the system is set up as a deal between the hospitals or the hospital systems or the other kinds of health-delivery organizations and the doctors. That puts a downward pressure on the people at the bottom of the pay scale. But in any country in the world, it's for low-power people, any capitalist country in the world, for low-power people to get respectable jobs, you need some combination of organization. Unions are the ones we know most, are the most clear historical example. But you also need institutional protections. So, you could think about a high minimum wage as something that could come out of this crisis even without a union movement. So, we have some union movement in the U.S. But for things like that to endure, you'd need to have some level of organization. And I think you talked before about solidarity. To the extent that the organization bridge's skill levels, bridges races, genders, professional degrees and non-degreed people, it's going to be inequality reducing.

KAO: Yeah.

TOMASKOVIC-DEVEY: Now that may actually mean lower wages for the people who now are very high-wage, including me and you.

KAO: Yeah.

TOMASKOVIC-DEVEY: Yeah.

KAO: Right. Well, on that realistic but aspirational note, I want to thank Professor Don Tomaskovic-Devey for being a guest on *Ethics Talk* today. Don, thank you for sharing your expertise and insights.

TOMASKOVIC-DEVEY: It was my pleasure. Thank you very much for having me.

KAO: For more COVID ethics resources, please visit the *AMA Journal of Ethics* as JournalofEthics.org. And to our viewing audience out there, be well and be safe. We'll see you next time on *Ethics Talk*. [bright theme music plays]