

Direct-Care Healthcare Workers: You Get What You Pay For

By Steven L. Dawson and Rick Surpin

Just don't get sick . . . and don't grow old either.
—advice of a home health aide

The long-term-care system in the United States long ago structured itself on the presumption of a seemingly endless supply of low-income individuals (usually women, and disproportionately women of color) willing to work as certified nurse's aides, home health aides, and personal care attendants. Both providers and consumers presumed that these workers would always be available to offer care and companionship in long-term-care settings—despite low-quality jobs that kept them working, but poor.

Now, however, direct-care staffing vacancies are spreading throughout nursing homes and home care agencies across the country (Paraprofessional Healthcare Institute, 2000). The very future of the industry now rests on an ability to attract direct-care workers within an increasingly competitive environment.

Of course, given that paraprofessionals in long-term care are paid primarily by American taxpayers, it could reasonably be argued that our long-term-care system simply has an obligation to create healthcare jobs that provide a livable wage, that our publicly funded healthcare system has a responsibility, at the very least,

*An unnecessary crisis in
long-term care?*

to guarantee its own workers health insurance. Yet, historically, moral suasion alone has failed to forge significant improvements in the quality of direct-care jobs. Perhaps

the new economic imperative will provide a more effective impetus.

Below, we argue that in order to survive, let alone provide high-quality care, the long-term-care system must restructure and must significantly improve the quality of paraprofessional employment.

LABOR AS A SCARCE RESOURCE

Today, the long-term-care industry faces a profoundly changed labor market. Nationwide, the pool of likely entry-level healthcare workers—women in the civilian workforce aged 25 to 44—is projected to decline by 1.4 percent during the next eight years (Fullerton, 1999). This particular population cohort is crucial, since it is the labor pool that has typically provided fresh recruits for the long-term-care industry.

Note in Figure 1 that the likely decline of this cohort of women in the civilian workforce follows three decades of significant expansion—nearly tripling from 1968 through 1998.

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Two interacting factors have caused the expansion of this female cohort during the past three decades: the increasing number of women from the baby boom generation coming of adult age and the increasing percentage of those women participating in the workforce (45 percent in 1968, rising to 76.7 percent in 1998). Now, however, the baby boom workforce has passed through this age range, leaving a smaller workforce to follow. Moreover, the rate of increase of participation of women in the workforce has slowed considerably, rising to only 79.5 percent for 2008, according to projections (Fullerton, 1999).

Because our long-term-care system developed during three decades of unprecedented labor expansion, it is little wonder that today, as traditional labor pools start to shrink, the industry is dazed and uncertain as to how to proceed. Although the nation's full-employment economy certainly exacerbates the situation—low-income women now have many more employment alternatives outside of healthcare—the hot economy is primarily a cyclical phenomenon that hides the deeper truth of the structural demographic shifts now occurring in the country's workforce.

In short, labor is becoming a scarce resource and will likely remain so even when the economy begins to cool (Judy, 2000). Therefore, the decades-old presumption of an endless supply of low-income women to feed, bathe, and comfort those in need of care is no longer valid. The system must change if it is to compete successfully with other employers.

A PUBLIC POLICY GULF

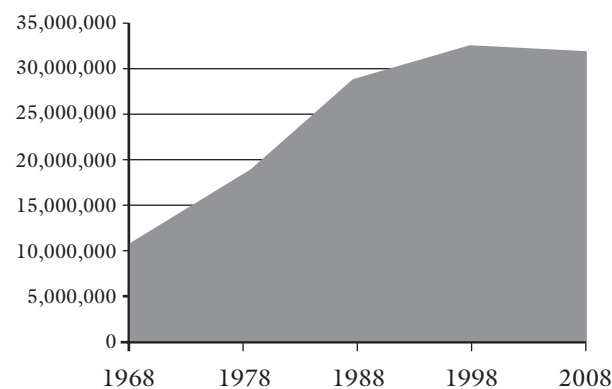
The low-income, direct-care worker stands at the intersection of three public policy worlds: healthcare policies designed to deliver long-term-care services, labor policies designed to improve employment prospects for all U.S. citizens, and welfare policies designed to help fam-

ilies living in poverty and people making the transition from welfare to work.

Healthcare policies. Since public tax dollars pay for the majority of long-term-care services, gov-

Figure 1
Women Aged 25–44 in the Civilian Workforce

1968–1998 and projected 2008



SOURCE: 1968 figure is calculated from Bureau of Labor Statistics. All other data are from Fullerton, 1999.

ernment regulations and reimbursements play a dominant role in the structuring and operation of our long-term-care system. Unfortunately, healthcare delivery policy has been designed without recognition of its impact on labor, particularly low-income workers. For example, reimbursement rates typically reflect past, not current, labor market conditions. When there is little competition for labor in the economy, this structure allows the healthcare system to “bargain” for workers at the lowest price possible. Yet when budget constraints collide with increased competition for labor, as is now the case, the healthcare system is unable to offer competitively attractive employment.

In addition, the very structure of direct-care work itself has been designed around the needs of financiers, providers, and clients—in that order—without regard to whether the resulting job offers a livable wage or decent working conditions. For example, homecare has been structured primarily around “morning care,” based on the desire of clients and the financial

savings derived from employing only a contingent, per-diem workforce. Yet the result is an entire industry built of part-time workers—sustainable perhaps in a high-unemployment economy, but now revealing itself to be unworkable during a period of intense labor competition.

Tellingly, the Health Care Financing Administration (HCFA)—the agency responsible for managing both Medicaid and Medicare—has itself stated that the paraprofessional jobs that it funds have overwhelmingly high turnover rates (Health Care Financing Administration, 1997). Yet when it issues proposed regulatory changes, HCFA assesses the likely impact on states, on providers, on physicians, and on clients—but not on direct-care workers.

Labor policies. The federal government invests more than \$8 billion annually to prepare Americans for new and better jobs. These funds are augmented by state and local funding. Although many government training and employment services are available to all citizens, the majority of services are targeted toward low-income and unemployed individuals.

However, state and federal employment agencies often preclude the long-term-care industry from participating in training support programs—on the basis that graduates of such programs cannot earn a livable wage as direct-care workers (New York City Department of Employment, 1999). While the public-policy basis for high-wage standards is clear (public employment programs do not want to support poverty-level jobs), the irony remains that these low-paying paraprofessional jobs are paid for primarily by federal and state health agencies.

Welfare policies. Since direct-care staff members typically are low-income women, they often find themselves both supported by, and entangled in, public-agency systems designed to improve their living conditions and increase their employment prospects.

For years, low-income women have straddled the two worlds of welfare benefits and healthcare employment. Some have moved back and forth between the two, leaving welfare for healthcare work but then cycling back to public assistance as soon as the next family crisis hit. Many other low-income women have continued to receive cash, food stamps, and other

forms of public assistance—even while employed as direct-care workers—because their part-time, direct-care jobs have offered only poverty-level income.

This interweaving of welfare and healthcare employment has long provided a hidden subsidy to the healthcare system. Providers could offer artificially low wages and no benefits, forcing their workers to rely, at least in part, on public assistance programs for the necessities of food, housing, and health insurance.

In 1996, Congress restructured welfare by passing the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA). In concert with a full-employment economy, PRWORA and state-level initiatives have resulted in a 50 percent reduction of welfare rolls nationwide over the past five years. Thus, in part because of welfare “reform,” our long-term-care system is now relatively less able to rely upon the welfare system to subsidize its direct-care workforce.

Furthermore, one primary intent of PRWORA was to increase work opportunities for welfare recipients. However, embedded within the law is a presumption, often referred to as “work first,” that discourages entry-level, skill-based training as a pathway to employment. This philosophy recommends “immediate attachment” of welfare recipients to a job—that is, securing any job as quickly as possible—without taking the time to invest in skill-based training. Therefore, although the federal government requires formal training before someone can become a home-health aide or certified nurse aide, the government simultaneously discourages low-income women from gaining access to training as a pathway to healthcare work.

The disconnect. Although health, labor, and welfare policies all affect the lives of direct-care workers, none of these policies is designed with the healthcare worker in mind. Furthermore, policy makes these three policy centers fail to communicate with one another on matters that might either support or harm the direct-care worker—even though the creation of a decently paid, well-trained workforce would serve the interests of all three. More troubling yet, coordinated planning and communication fails to occur even within the U.S. Department of

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Health and Human Services, which is responsible for designing and implementing both healthcare policy and welfare policy.

DIRECT-CARE LABOR MARKET DYNAMICS

As is true for every sector of the economy, employers in healthcare compete for workers within a dynamic labor market (Burbridge, 1993; Seavey, 1999). However, if the healthcare labor market were functioning perfectly, direct-care vacancies would not continue for long. That is, incumbent and potential workers would become increasingly attracted to the healthcare system as healthcare employers adjusted upward the “price” they paid for labor (wages, benefits, and working conditions) to remain competitive within the marketplace.

Unfortunately, several factors prevent our healthcare system from achieving rapid labor-market “equilibrium” to fill available positions. To understand this imperfectly functioning labor market, it is necessary to sketch the dynamics of labor demand, supply, and price within the long-term care industry.

Factors of labor demand. Demand for healthcare workers is pushed by such factors as the aggregate number of consumers living with higher levels of acuity and consumers’ strong preference to receive services within their homes. These demand factors are now multiplying and are creating geometric pressure for increased direct-care services.

However, while these multiple factors push the “need” for more labor, other attributes of the healthcare industry suppress, or at least distort, labor’s “effective demand” (that is, the level of services that payers are able or willing to purchase). In particular, since healthcare is funded largely by public and private third-party payers who have strong financial incentives to limit costs, “effective demand” (as determined by those third-party payers) will nearly always be less than the “need” perceived by either consumers or their health service providers.

For example, government third-party payers must apportion tax dollars to an array of public services, healthcare being only one among many. Similarly, private insurers—accountable to shareholders and corporate purchasers—have created capitation arrangements, utilization reviews,

and rigorous definitions of what constitutes “medically necessary services” in order to control costs. Therefore, completely independent of increased requests for health services, third-party payers may choose to constrict, or perhaps even reduce, “effective demand” for long-term-care services, which in turn suppresses effective demand for labor.

In short, the healthcare labor market can best be understood as driven by massive demographic forces accelerating aggregate demand for services. Simultaneously, powerful third-party payers attempt to brake that demand through regulatory constraints and cost-containment measures. Therefore, we can reasonably expect a continued expansion of effective demand for healthcare-related labor, but an expansion that is likely to remain irregular and balky, depending largely on political and financial—not simply care-related—factors.

Factors of labor supply. As noted earlier, the pool of likely entry-level workers—women in the civilian workforce aged 25 to 44—is projected to decline by 1.4 percent during the next eight years. Worthy of particular note is that these projections already have taken into account welfare reform, which has forced millions of low-income women off of the welfare rolls and into the workforce.

Therefore, it is not surprising that many providers, faced with ever-deepening vacancies, have called for relaxed immigration to “refill” the pool of low-income women (Essential Worker Immigration Coalition, 1999). However, projections of a shrinking labor pool already assume relatively high net international annual migration levels, ranging between 780,000 and 950,000 through the year 2030. Furthermore, only a small portion of immigration visas (less than 13 percent over the past five years) are employment-related. Of these employment-related immigrants, more than half are professionals or other highly skilled workers (Hollmann, Mulder, and Kallan, 2000).

With the nursing home industry alone calling for 250,000 new direct-care workers (American Health Care Association, 2000), it is apparent that only a substantial loosening of immigration policy would meaningfully expand the pool of potential direct-care staff. Yet unless relaxed immi-

gration were also linked to requirements for livable wages and benefits for direct-care staff, any expanded targeting of immigrants for paraprofessional jobs would have to address the political and economic realities of importing hundreds of thousands of low-wage workers—individuals whose essential needs for food, housing, child-care, and transportation would have to be significantly subsidized by taxpayer dollars.

Restrictions on 'labor price.' As noted above, a more typically flexible labor market would respond to the system's current mismatch between supply and demand by improving wages, benefits, and working conditions. However, not only do third-party payers play a primary role in determining effective demand, they also indirectly (and sometimes directly) influence "labor price" by determining the amount of money public agencies and private insurers are willing to pay per client, per illness or episode, or per visit. In addition, public regulators affect direct-care "productivity" by the amount of non-service activities (i.e., paperwork) they require of providers.

Therefore, provider agencies are often severely limited by this third-party-payer constraint. In periods of high degrees of competition for labor, if reimbursement fails to keep up with the true cost of providing services, provider agencies have correspondingly less flexibility with which to address the labor market. Third-party payers have thus played a significant role in suppressing wages and benefits artificially below the levels necessary to attract and retain quality staff.

Nonetheless, although third-party payers constrain provider flexibility, agencies do retain a degree of discretion over the allocation of total reimbursements among the full range of agency costs and profitability. After all, direct-care wages and benefits do vary even among employers within the same segments of the industry.

Furthermore, although wages and benefits are an essential part of labor pricing, working conditions are equally important. Working conditions include a broad array of factors, from the tangible (part-time employment or unsafe workloads) to the intangible (feeling "respected") and much in between (good training or opportunities to advance). In recent focus groups in New England, current and former

direct-care workers reported multiple examples of insulting supervisory practices and sometimes dangerous working conditions; they also reported that working conditions were equal in importance to wages and benefits in their decisions to remain employed by, or to leave, employers in healthcare (New Hampshire Community Loan Fund, 1999).

Providers retain a large degree of control over working conditions within their agencies and facilities, and improvements in the quality of supervision and the workforce culture can often be implemented at relatively limited expense. In addition, costs associated with improving the price of labor should be offset at least partially by savings generated from reduced turnover.

CONCLUSION: YOU GET WHAT YOU PAY FOR

Given that options for expanding the general labor pool are likely to remain very limited—and that the number of "traditional" entry-level caregivers is actually shrinking—one realistic path remains open for the long-term-care industry: competing successfully against employers outside of healthcare for workers. Put bluntly, only by improving the quality of direct-care positions relative to the rest of the labor market can healthcare employers hope to recruit and then retain a stable paraprofessional staff.

However, successful competition essentially requires improving the price of labor—that is, increasing wages, benefits, and working conditions. In turn, effectively improving the price will require full recognition of the following premises.

- Because of the predominance of government funding, direct-care workers are essentially "public employees once removed." Therefore, increasing the competitiveness of direct-care employment will require fundamental political choices.

- Direct-care workers are entangled in three disparate policy worlds—health, labor, and welfare—and thus an effective response will require a "cross-sector" strategy that improves communication, planning, and coordination between departments of labor and health and human services at, and between, both the federal and state levels.

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• Although funded primarily by government, direct care is nonetheless implemented through private providers who retain significant control over—and therefore responsibility for—the quality and structure of direct-care jobs.

Finally, the essential elements that frame a competitively attractive job are neither difficult to imagine nor presumptuous in scope. They are likely to be what any individual—particularly someone with the benefit of several employment options—would ask of an employer. The five essential elements are as follows:

1. A “family wage,” health insurance, and other benefits.
2. Balanced and safe workloads that offer full-time employment but do not overwork employees.
3. Appropriate training standards.
4. Opportunities for advancement and professional development.
5. Support for employees—both on the job (e.g., improved supervision) and in the community (e.g., affordable childcare).

Although this analysis might at first appear daunting, the relatively good news is that the staffing crisis has seized the attention of all three key stakeholders in long-term care: providers, consumers, and organized labor. With all three groups focused on the same issue, an opportunity now exists for leaders from each to set aside their differing perspectives and join forces in unprecedented coalition to improve the competitiveness of direct-care jobs.

To do so will void the crisis. Otherwise, the wealthiest healthcare system on earth will continue to perpetuate reliance on workers in poverty-level jobs, offering to its most vulnerable citizens care that is not of the highest quality—and, increasingly, foregoing care altogether. ❧

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Adapted, with permission, from Direct Care Health Workers: An Unnecessary Crisis in Long-Term Care, published by the Domestic Strategy Group of the Aspen Institute, Washington, D.C.

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