Improving Job Quality: Direct Care Workers in the US

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September 2011

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Acknowledgments

The authors thank Sophia Parker of the Resolution Foundation for comments and assistance with the UK comparison. A version of this report will be published later this year by the UK Living Standards Commission

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Introduction

Around the seminar rooms of Washington, there is much talk about the need for an industrial strategy to support sectors of the economy with the most potential for employment growth. Often the focus of these discussions is infrastructure investment and green jobs. Below the surface, however, is a nagging concern on the part of the Obama administration about the sharp decline in the employment-to-population ratio of men in their prime working years. Although this development preceded the recent recession, it was greatly exacerbated by it.

In part the decline can be explained by the dominance of women in the American industries exhibiting the strongest growth in payroll employment in the years prior to the downturn – education and health services.[1] Even as the recession led to a collapse of employment in the rest of the economy, privately provided education and health services added 844,000 jobs.

TABLE 1
Fifteen Occupations with Largest Projected U.S. Job Growth, 2008-2018

	2008 National Employment Matrix Occupation	Code Median Annual Wage Quartile	Percent Female 2008	Percent Black 2010	Percent Hispanic
1.	Registered nurses	VH	91.0	12.0	4.9
2.	*Home health aides*	*VL*	*88.2*	*34.6*	*14.7*
3.	Customer service representatives	L	66.6	17.5	15.2
4.	Combined food preparation and serving workers, including fast food	VL	61.3	12.8	16.6
5.	*Personal and home care aides*	*VL*	*86.1*	*23.8*	*17.6*
6.	Retail salespersons	VL	51.0	11.3	13.7
7.	Office clerks, general	L	84.2	13.0	15.6
8.	Accountants and auditors	VH	60.1	8.6	5.8
9.	*Nursing aides, orderlies, and attendants*	*L*	*88.2*	*34.6*	*14.7*
10.	Postsecondary teachers	VH	45.9	6.3	5.0
11.	Construction laborers	L	2.7	9.0	43.1
12.	Elementary school teachers, except special education	H	81.8	9.3	7.3
13.	Truck drivers, heavy and tractor-trailer	H	4.6	13.6	17.5
14.	Landscaping and grounds-keeping workers	L	N/A	N/A	N/A
15.	Bookkeeping, accounting, and auditing clerks	H	90.0	6.5	8.8

Source: Employment Projections Program, U.S. Department of Labor, U.S. Bureau of Labor Statistics, www.bls.gov/emp/ep_table_104.htm and Employed Persons by Detailed Occupation, Sex, Race and Hispanic or Latino Ethnicity, www.bls.gov/cps/cpsaat11.pdf

1 In December 2007, at the start of the recent recession, the private (i.e., for-profit) education and health services sector was 77 percent female and employed 14.3 million women – in contrast to construction, which was 87 percent male and employed less than half as many – 6.5 million – men.

Between December 2007 and April 2011 employment in education and health services increased by seven percent as the sector added more than 1.3 million jobs; home health care jobs alone grew by 20 percent. Overall it is predicted that paraprofessional jobs in healthcare will grow three times faster than all other occupations in the years to come.[2]

These jobs are unattractive to men because of the very low wages paid – too low to support a family- but also because of cultural stereotypes. The marginalized status of occupations in paraprofessional health care in terms of wages, benefits and employment law protections is a legacy of the politics of race and gender in the US as it applied to work performed in what was viewed as the domestic sphere. In the New Deal of the 1930s, the economic interests of the South shaped the legal framework surrounding domestic service. Unwilling to expand the political or economic power of African Americans and seeking to maintain an inexpensive supply of labor, Southern politicians worked to exclude domestic service (and farm labor) from the New Deal labor reforms.

The historical legacy that shapes America's care market today may be unique to the country, but there are some strikingly similar labor market trends in Britain. Demand for care and support in England and Wales is projected to rise sharply in the coming decades just as it is in America. Scenario work by the Department of Health suggests that an ageing population and medical advances will expand the care workforce in England to 2.6 million people by 2025 – the equivalent of 3.1 million jobs, of which a third will be personal assistant or directly employed care worker roles. Even in a more conservative scenario, this means that the care sector is expanding rapidly at a time that many other sectors – particularly those that have historically been dominated by men – are in decline.

These shifting patterns of growth across different sectors of the economy must be reflected in the industrial strategies of both nations as our governments search out ways of kickstarting an economic recovery. And that means focusing on what can be termed 'low productivity' sectors such as health and social care, as much as high technology and green jobs: these are sectors which will employ growing numbers of low earners, who rely on their work to support their families. Starting with this premise, we offer here an overview of what the latest American research and practice tells us about how to invest in job quality in this poorly understood sector.

This essay focuses on the paid workforce in social care, rather than the huge army of unpaid carers – mostly family members – who play such a vital role in both countries. Workforce issues have historically been marginalized in debates in England. Even with a recent surge of interest – see for example the publication of a workforce development strategy[3] and a forthcoming framework for Personal Assistants[4] – it is difficult to see how a policy agenda that aims to reduce regulation, coupled with major austerity measures, will lift care work from being a 'Cinderella profession encumbered with negativity'[5] to a career of positive choice that provides people with job satisfaction and economic security.

2 Dawson (2007).
3 Skills for Care (2011).
4 It has been reported that the Department of Health will produce a strategic framework for personal assistants. See for example http://www.communitycare.co.uk/Articles/2011/06/06/116947/the-employment-rights-of-personal-assistants.htm
5 Skills for Care (2011b).

Drawing on American research, this essay argues that an industrial strategy for the health and social care sector will need concrete policies that raise wages, improve working conditions, provide opportunities for career mobility, as well as initiatives to increase the dignity of the paraprofessional health care workers who provide hands-on, non-medical care services – personal or home care aides, home health aides, and certified nursing assistants and orderlies. These changes are essential for maintaining a vibrant middle class.

A Cinderella Workforce

While health care is organized very differently in America and England, both countries provide personal and social care via a mixed economy, where providers operate in either the government or the voluntary or private sector, and where care is paid for by a combination of means-tested publicly-funded support and individual contributions. In addition, informal unpaid care shores up a chronically underfunded sector in both countries – there are an estimated five million unpaid carers in England, 46 per cent of whom are juggling their responsibilities at home with paid work.[6] 61.6 million Americans provided care at some point during 2009, with an estimated economic value of $450 billion – an increase of $75 billion since 2007, and a value equivalent to 3.2 per cent of GDP.[7]

Looking at the paid workforce within this mixed economy of care in America, jobs are treated as unskilled work, with little regard for the knowledge, communication skills and emotional requirements of providing quality care. Training is mostly informal and 'on-the-job', with most states in the US requiring workers to complete just 75 hours of formal training. Furthermore, as Table 1 shows, these are also very low wage jobs, with pay falling into the bottom quartile of earnings. Employer-paid health insurance and pension schemes – indicators of job quality – are unusual, with less than half of home health aides and home care aides having access to such a scheme. Indeed a third of these workers have no health insurance at all.

While English care workers do not need to pay for health insurance, their job quality is worryingly low for a sector projected to grow so significantly in coming years. It is low paid and dominated by women, who undertake between 85 and 95 per cent of all direct care and support-providing jobs in England. In 2009, median gross hourly pay for care workers varied between sectors but no one was well-paid, and jobs offering the minimum wage or near this are common. The £6.00 an hour paid in 2010 to carers in the private sector was 50 pence less than the median pay for supermarket check-out workers.[8] Britain may do better than America at ensuring its 1.75 million care workers have basic work supports, such as paid sick leave and annual holiday allowances, but it remains the case that basic pay is low and training opportunities are limited. One in eight low paid jobs are in the health and social care sector,[9] and the Low Pay Commission has repeatedly expressed a concern that social care budgets are failing to reflect minimum wage requirements.[10]

At the same time as a rapid expansion in the *number* of jobs available, the *nature* of work in the health and social care sector is changing. Domiciliary or home care work is growing faster than institution-

6 NHS Information Centre (2010).
7 Feinberg, Reinhard, Houser, and Choula (2011).
8 Eborall, Fenton, Woodrow (2010).
9 Resolution Foundation (2010).
10 Low Pay Commission (2011).

based care in both countries: for example, by 2018, 800,000 of the projected 1.3 million paraprofessional care positions in America will be in home-based care. And consumer-directed care – whereby people receive Direct Payments from which they pay for the costs of their care – is also growing rapidly. There were 168,000 unregulated personal assistants in England in 2010, and this is predicted to rise to 722,000 in 2025, meaning greater numbers of workers will be employed directly by those for whom they care.[11]

While these developments may have positive outcomes for many people wishing to be cared for at home, they have more ambiguous implications for the workforce unless there are changes to the regulatory and cultural environment of the sector. Care work that is carried out behind people's front doors is hard to monitor. Direct Payment recipients who are unfamiliar with the responsibilities of being an employer may not enforce the rights of their workers. A fragmented workforce makes individual, structured and organized approaches to career development extremely challenging.

In the light of these working conditions, it is hardly surprising that turnover is a long-standing problem in this industry. The persistent high rate of turnover in many areas is a critical and unresolved factor contributing to staff shortages, poor quality care and unnecessary costs of long-term care. A 2002 national survey of American nursing homes found annual turnover rates among certified nursing assistants to be greater than 70 per cent and average vacancy rates to be almost 12 per cent.[12] These are far higher than the equivalent figures in England, but at 3.1 per cent, vacancy rates in social care are still twice the level for all industrial, commercial and public sector activities. About one in four English care workers leave their jobs each year, with turnover being more pronounced among lower paid staff than managers.[13]

Management Practices and Work Organization

Care is provided in a variety of locations. Despite a shift towards home-based care in recent years, much long-term care continues to be provided in sometimes dismal institutional settings: America has 17,000 nursing homes and another 900,000 older people reside in assisted living facilities. As in England, serious concerns about quality persist,[14] notwithstanding improvements in clinical care in nursing homes over the last two decades.

The workloads of frontline nurses and aides in the vast majority of nursing facilities necessitate a constant triage and priority setting among the most immediate and pressing needs of residents, constraining the ability of staff to meet residents' needs for social contact and individualized attention.[15] Levels of reimbursement from the major payers do not support increased staffing,[16] and

11 There were 114,500 recipients of direct payments in 2010 – compared to 76,642 in 2007/08. See Eborall, Fenton, Woodrow (2010) and ibid.

12 Decker, Gruhn, Matthews-Martin, Dollard, Tucker, and Bizette (2003) More recent data shows that the turnover rate among certified nursing assistants is about 65.6 per cent, while the vacancy rate is 9.5 per cent. There are an estimated 60,300 certified nursing assistant positions vacant. See American Health Care Association: Department of Research (2008).

13 Eborall, Fenton, and Woodrow (2010), ibid.

14 Institute of Medicine (2001), Levinson (2008), and Harrington, Carrillo, Blank, and O'Brian (2010).

15 Baker (2007).

current reimbursement levels threaten to compromise the ability of nursing homes to deliver quality care.[17] The situation is complicated by the fact that long-term care is often a profit-seeking endeavor in England and the US. 73 per cent of England's homes are private sector, as are 65 per cent of America's homes, and the majority of these are operated by large firms or chains. There is widespread concern and some evidence that for-profit facilities may sacrifice patient quality and safety in the interests of profitability.[18]

In light of these concerns, there has been a groundswell of interest in America about the potential impact of introducing 'high performance' work practices into this sector as a means of improving both job and care quality. As researchers begin to study work organization and human resource management practices in hospitals and nursing homes,[19] it is clear that such practices are correlated with a broad array of desired outcomes.[20]

Taken together, the findings of studies in this area are instructive: greater job attachment and higher quality care will result from management practices that support a high-trust environment, 'psychological safety' to admit to mistakes and learn from them, high quality communication, mutual respect and shared goals. These findings reflect the broader literature on 'high-performance' work systems – the modern means of generating high productivity, high service quality and high wages.

As ever, the challenge rests in convincing employers in the care sector to adopt these high performance practices. A national American survey by the Commonwealth Fund in 2007 found that only five per cent of nursing homes report having comprehensively adopted these person-centered practices. Responding to the need for more care institutions to take up the challenge, the Robert Wood Johnson/Atlantic Philanthropies' Better Jobs/Better Care initiative provided funding for interventions intended to alter human resource management practices in long-term care settings with the goal of improving – and in some cases transforming – the quality of care in nursing homes.

The interventions center, variously, on the quality of supervision of direct care workers, peer mentoring programs, addition of support personnel to advocate for workers and improve retention, establishing career paths, and instituting empowered work teams. The results of these studies are promising, with results generally in the expected direction though sometimes mixed.[21]

Interventions such as these confront numerous challenges in the structure and the culture of the care sector as it stands today. For example, empowered work teams are trained and encouraged to respond to the individual needs of care recipients, but have difficulty doing this and completing other tasks. Job enhancements and other interventions may have limited impact, given the typical workloads of nursing assistants in long-term care facilities. Workers receive training, but have limited opportunities to increase wages or move into more responsible jobs, as the proportion of jobs that utilize these skills remains low.

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16 Institute of Medicine, Committee on the Future Health Care Workforce for Older Americans, and Board on Health Care Services (2008).

17 Ash and Basu (2009), and Johnson, Oliff, and Koulish (2009).

18 Pear (2008).

19 Gittell., Weinberg, Pfefferle, and Bishop (2008).

20 Appelbaum, Bailey, Berg, and Kalleberg,(2000).

21 Morgan and Konrad (2008) and Kemper, Brannon, Barry, Stott, and Heier (2008).

Thus, while studies of the effects of interventions to improve work organization and management practices suggest that improving human resource management can improve both job quality and the quality of care, the structural and institutional constraints on staffing and upward mobility in long-term care facilities continue to limit the effectiveness of these interventions.[22]

Improving Job Quality in an Era of Home-based Care

Domiciliary care is set to rise faster than institution-based care: personal and home care aides and home health aides are the third and fourth fastest growing detailed occupations in America and, as shown in Table 1, have the second and fifth largest projected job growth.[23] Furthermore, an increasing proportion of state funding for social care is being channeled into 'consumer-directed' care – better known as personalization or self-directed support in England. Direct Payments to care recipients enable them to hire direct care workers themselves, including friends or family members. This growth in home-based care workers is an important development from the personalization agenda, but it makes it harder than ever to regulate and improve job quality.

In 2011 a broad-based American coalition that includes unions engaged in organizing direct care workers, the National Domestic Workers Alliance, the National Employment Law Project, advocates for a higher minimum wage or for paid sick days, and numerous community groups and NGOs launched a major initiative – *Caring Across Generations* – to improve the quality of work for direct care workers working in people's private households. This model is one that could certainly be imported to England.

The goal of this coalition is to pass comprehensive legislation to address the multiple disadvantages of care workers in health services and to improve clients' access to affordable quality care. Reforming employment law so that personal and home care workers are covered by wage and hour laws, occupational health and safety laws, family and medical leave laws, and union organizing rules is fundamental to changing the policy framework for these workers and overcoming their marginalization in the labor market. Beyond these legislative changes, the coalition is campaigning for a series of other improvements, two of which are particularly pertinent to the English situation.

Workforce Intermediaries

First, there is a great deal of work going into creating workforce intermediaries – organizations that aim to aggregate workers and provide benefits to them and care recipients. Much of this work takes inspiration from earlier organizing efforts in California by the Service Employees International Union (SEIU) – one of America's largest unions. The SEIU's work showed how intermediaries can make it easier for workers to reach fair pay agreements with states. They can provide other services to both consumers and workers, such as access to background checks, worker registries and training. Our experience in America indicates that incentives are needed to attract private pay workers, hired directly by care recipients or their families, to join such intermediaries – such as training opportunities, systems to provide backups in case of emergency, worker screening and fiscal intermediary services.

22 Wellin (2007).

23 U.S. Department of Labor, Bureau of Labor Statistics (2011).

States where intermediaries have been successfully set up, such as California, show that they not only improve working conditions for direct care workers, but also help families to access state and federal funding for which they are eligible. Research by Howes (2002, 2004, 2005) into the Californian initiative documents a near doubling of wages for homecare workers, an increase in both the number of workers and the number of consumers served by the program, and a decline in various measures of turnover.

The labor movement has successfully extended this model to provide basic labor protections to home care workers in eight states and to family day care providers in ten states. The Caring Across Generations coalition is now campaigning for states to be required to set up intermediaries, and enable workers to bargain with the state if a majority so chooses.

Career Ladders and Training

The second campaign area of potential interest to English readers is the focus on training and career ladders for personal and home care workers – which are currently sorely lacking on both sides of the Atlantic. Here in the US, *Caring Across Generations* is pushing for a minimum national training standard, which would apply to all workers providing care paid for by state funding. This standard would increase the federal requirement for entry training for home health aides from 75 to 150 hours, as well as making training costs for home care workers eligible for reimbursement from the government, as they are for nursing home workers.

Given that one in five domiciliary care agencies did not meet the qualifications-related National Minimum Standards in England, there is much work to be done in England. Recent calls by Skills for Care to link training to remuneration frameworks are welcome and should be pursued. There is also campaigning work going on in America to establish clearly articulated home care career pathways by defining a national Personal and Home Care Aide credential. Much more work is needed in the US to build a rationalized system that builds formally from one level of training to the next, with certifications for each that are transportable across settings and employers. The new Qualification and Credit Framework in England may have much to offer here but it needs to be evaluated.

Conclusion

England spends £122 billion each year on health and social care – roughly a fifth of all public expenditure.[24] Much of this money is spent on the workforce, and yet care work remains a poorly paid profession with high turnover, low morale, and few opportunities for advancement.

At the center of any strategy for improving job quality in this sector is decent public sector investment. This may seem an obvious point, but it is a vital one, given the planned cuts in public services on both sides of the Atlantic. Such cuts will make it hard for providers to meet even current levels of demand, let alone be ready for the future. It has serious implications for low earners relying on jobs in the care sector for their economic wellbeing.

24 Skills for Care (2011b), ibid.

Beyond funding, as this essay shows, better jobs will come from a steady focus on three priorities: improving employer practice, appropriate regulation and workforce organizing. At a more fundamental level both American and British policy makers need to stop treating care as low-paid 'women's work' that is incidental to a family's income. Social care is a growth sector and must be considered alongside green jobs and infrastructure investment when it comes to developing industrial and economic policy.

Improving job quality matters from a care quality perspective: the outcomes of care recipients are deeply intertwined with the fortunes of care workers. Morally, it is incumbent upon nations to care for the sick and elderly with dignity and respect. But improving job quality in the fields of health and social care is also critical for economic reasons: care work is a growing sector, and more low earning households than ever before will be relying on care jobs to raise their families and ensure a decent standard of living.

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