

New England Journal of Public Policy

Volume 13

Issue 1 *Workforce Development: Health Care and Human Services*

Article 8

9-23-1997

From Welfare to What?: The Limitations of Low-Income Work

Lande Ajose

Massachusetts Institute of Technology

Follow this and additional works at: <http://scholarworks.umb.edu/nejpp>

 Part of the [Medical Education Commons](#), [Public Health and Community Nursing Commons](#), and the [Public Policy Commons](#)

Recommended Citation

Ajose, Lande (1997) "From Welfare to What?: The Limitations of Low-Income Work," *New England Journal of Public Policy*: Vol. 13: Iss. 1, Article 8.

Available at: <http://scholarworks.umb.edu/nejpp/vol13/iss1/8>

This Article is brought to you for free and open access by ScholarWorks at UMass Boston. It has been accepted for inclusion in *New England Journal of Public Policy* by an authorized administrator of ScholarWorks at UMass Boston. For more information, please contact library.uasc@umb.edu.

From Welfare to What?

The Limitations of Low-Income Work

Lande Ajose

The premise of the welfare law enacted by Congress is that people living in poverty could vastly improve their economic status if only they were employed. The author argues that economic security for welfare recipients will not be realized simply by increasing the labor-force attachment. Home health aides comprise an occupation that could absorb many of the large pool of workers expected to join the labor market because demand for their services is high and barriers to entry are low. However, as this survey shows, the home health field offers limited promise to welfare recipients because, significantly for women rolling off welfare, it is among the increasing number of jobs in the economy that offer low wages and few benefits.

The not-so-subtle message of the welfare law enacted by Congress is that people living in poverty could vastly improve their economic status if only they were employed. The argument supporting this claim is that welfare recipients would be better off because they have would have sufficient income to meet their needs. Provisions in the Temporary Assistance for Needy Families Block Grant (TANF) to both time-limit welfare and mandate work participation assume that labor-force participation leads to self-sufficiency, if not in the short term, that is, in a welfare recipient's first exposure to the labor market, then at least in the long term, in a second or third job or substantial tenure in a first job. These provisions are even more serious in Massachusetts, where welfare reform has been under way since November 1995. Members of more than 82,000 Massachusetts households receiving welfare are expected to secure jobs within the next five years, but this is probably a conservative estimate. Since states are allowed to exempt up to 20 percent of their caseload from the time limit, the figures represent 80 percent of the Aid to Families with Dependent Children (AFDC) clients.

I believe that the promise of economic security for welfare recipients will not be realized simply by an increased labor force. The work of Kathryn Edin and Rebecca Blank provides some clues as to why this is so. Both argue that employment ignores the issue of livable wages once a welfare recipient enters the labor force. According to Edin, even though the premise of current legislation is that welfare recipients are dependent while those who are employed are self-sufficient, this, in fact, is not the case. Many public policies designed to assist welfare recipients ignore the real costs incurred

Lande Ajose is a doctoral student, Department of Urban Studies and Planning, Massachusetts Institute of Technology.

by a recipient and her family when she gains employment. As Edin notes, “Policy-makers must determine which jobs at what wage are needed to successfully bring welfare mothers and their families into the economic mainstream.”¹ Blank asserts that employment will make very few recipients better off because 95 percent of AFDC recipients would earn so little that they would still be eligible for AFDC assistance.² It seems that, at best, jobs in many of the occupations they might be able to fill would simply move them from the ranks of the welfare dependent to the ranks of the working poor.

“The welfare problem has been defined as one of labor force participation at any level, because once a mother gets a job, policymakers assume she will move up.”³ Understanding the likelihood of escaping poverty requires examining the structure of local labor markets in which former welfare recipients might be hired. This should include a detailed analysis of potential occupations with a clear understanding of skills and training required for work, the wages and benefits such work would provide, attention to the quality of the job, and its potential for further growth through career ladders.

I examine the home health aide occupation as a potential source of employment and self-sufficiency for those coming off the welfare rolls. The home health care industry appears to hold much promise of work for them. First, its “barriers to entry” are relatively low. It specifies few formal educational requirements since neither a high school diploma nor a college degree is required. Second, to reduce costs, changing insurance schemes mandate that more people receive health care services at home rather than in institutional settings like hospitals. Third, the aging population, particularly in the baby boomer generation, suggests that there may be sustained demand for the services of home health aides, particularly through managed care systems. Finally, health care services are necessary and provided countrywide. Consequently, job opportunities exist in all areas, cities, suburbs, and rural.

Despite the home health industry’s apparent promise for low-skilled workers, a central question remains: What are its prospects for moving large numbers of people off welfare and into the labor market, and more important, into self-sufficiency? My objectives are twofold. First, I attempt to document the structure and dynamics of the home health care industry with a view to understanding the opportunities for worker independence. I focus specifically on home health care in the Boston metropolitan area, which has a very strong and well-developed delivery infrastructure and provides an ideal subject for analyzing this subsector of the health care delivery system. Second, if, as I suspect, a career in home health care has limited growth potential because of its low wages and minimal benefits, what are the possibilities for advancement? The work of anthropologist Katherine Newman provides some clues regarding the promise of low-wage work for welfare recipients.

McJobs

Newman has been studying opportunities for unemployed people in Harlem to obtain minimum-wage work in the fast-food establishments that overrun the neighborhood. The fast-food industry, she charges, is one of the fastest growing service industries, providing employment “typical” of what we might expect labor-market entrants to consider.⁴ Her work is particularly useful because Newman offers some insight as to how AFDC recipients might fare in the labor market compared with their job-seeking counterparts. Her research tracks the employment outcomes for 200 people who applied for minimum-wage jobs in Harlem, only half of whom were hired.

In “The Job Ghetto,” Newton and coauthor Chauncy Lennon found that it is not as easy to get a low-wage job as one might think. Their study shows that there is fierce competition for unskilled jobs in Harlem. With the supply of labor largely outstripping the number of jobs, successful applicants must possess credentials far in excess of what they actually need to perform their work.⁵ This “creeping credentialism” puts welfare recipients at a clear disadvantage in their competition with more credentialed, and more experienced, job seekers.⁶

In a separate study, Newman also found that U.S.-born minority applicants are less successful than immigrants in securing employment. She suggests that this may be attributable to racial stereotypes about African-American workers. Employers find immigrant workers more agreeable and less dissatisfied with their low wages, as they come from countries in which their earnings would be considered quite substantial. As a result, immigrants are preferred to American blacks.⁷

Finally, Newman’s work suggests that low-wage jobs in the fast-food industry lead to very little job mobility. While there is an internal promotion pattern for workers, its steep pyramidal structure strictly limits opportunities for advancement. Furthermore, the efforts of fast-food workers (full-time employees earn about \$8,840 before taxes) to seek higher wages in other industries, such as retail and other service sectors, reap meager fruit. As a result, many become trapped in low-wage jobs.⁸

While there is no strict comparison between fast food and home health care, there are some striking similarities. Employers seek credentials from certified home health aide applicants in excess of what is necessary, for example, prior job experience and strong references. To the extent that long-term welfare recipients have been out of the workforce for some time, they are at a disadvantage in comparison with other home health aides. Also, as in other areas, there is evidence suggesting that immigrants are hired in greater numbers than U.S.-born workers. Most employers indicated that the strong social networks in immigrant communities were a contributing factor, though a few mentioned a reticence to hire welfare recipients. Finally, home health aides face serious barriers to advancement, stemming mostly from the structure of the industry. These parallels suggest that home health care may offer limited opportunities for welfare recipients entering the labor market.

There are also some important differences between this study and Newman’s work. On the positive side, while Newman focuses on a rather geographically defined area, which by its very nature suggests that the number of applicants per job would be high, most home health aides must travel out of their neighborhoods to secure work. This implies that competition for work would not be as fierce in home health as in fast food. On the negative side, however, there may be some logic in the creeping credentialism of home care. Unlike fast-food workers who operate in a highly supervised environment, home health aides have little daily supervision, and making a mistake is costly. Thus, a higher threshold for employment that demonstrates an aide’s capacity to assume responsibility might be warranted.

The Home Health Industry

Recent figures from the Department of Economic Development estimate that the health care industry accounts for as many as 176,000 jobs in the Boston metropolitan area.⁹ While overall the health care service sector is growing, certain subsectors are decreasing in size, as evidenced by continuing hospital consolidations. In 1994, for example,

3,600 hospital jobs were lost. This decline, however, was offset by an increase of 7,600 positions in private health care services, spelling good news for the home health care subsector.¹⁰

But there is a dark side to this brimming demand for home care. First, the changing composition of employment within institutional settings will have a disproportionate impact on low-income women of color who have traditionally relied on hospital employment as a means of entering the labor force.¹¹ It is anticipated that shifts in hospital staffing patterns will have a particularly deleterious effect on these workers, who comprise as much as 80 percent of the help within the industry.¹² Because the home care wage structure is substantially lower than that of institutional settings, it is unlikely that this population will create a considerable increase in competition for home care positions.¹³ However, those who find themselves unemployed for longer than anticipated may encounter competition, which is most likely to result among noncertified home health aides.

The employment structure of the health care industry is an example of an enterprise with dual labor markets, a theory originally developed by Peter Doeringer and Michael Piore. It is their thesis that primary markets comprise all the features generally associated with good jobs: high wages, good working conditions, job security and stability, and opportunities for advancement. By contrast, secondary labor markets are characterized by low wages, low benefits, poor working conditions, high job turnover, and low job security.¹⁴ The theory asserts that certain workers "are confined to the secondary market by residence, inadequate skills, poor work histories and discrimination."¹⁵ The theory also maintains that despite the disadvantages low-income workers face as members of secondary labor markets, there is a way to break out of low-wage, dead-end jobs. In the presence of economic growth, education and training programs, and equal opportunity programs, it was postulated that there could be labor mobility between secondary and primary markets.¹⁶ Furthermore, in the 1973 revision of the labor theory of duality, Piore asserted that the primary labor markets are further divided into upper and lower tiers, suggesting that there may be an articulated career ladder between the two.¹⁷ Certainly the 1980s witnessed tremendous economic growth, buttressed by such federal job-training programs as the Job Training Partnership Act and the existence of affirmative action programs. Nevertheless, secondary labor markets continued to exist and, according to Bennett Harrison, are in danger of being institutionalized.¹⁸ As the following section shows, occupations within home health care bear a remarkable resemblance to the secondary labor markets in institutional settings.

Home Care Occupations

There are two types of home care occupations, one requiring relatively skilled and the other comparably unskilled personnel. Skilled practitioners encompass nurses (R.N.'s) and various therapists, including speech, respiratory, occupational, and physical. The Home Care Association of America categorizes unskilled home care aides in four levels: Home Care Aide I, commonly referred to as a homemaker, is the least skilled and lowest paid; Home Care Aide II designates a personal care aide; Home Care Aide III is a home health aide; and Home Care Aide IV, the rarest of all, is a specialist. Table 1 outlines the responsibilities of each level. According to the Bureau of Labor Statistics, home care occupations are among the fastest growing in the nation. It has been estimated that the number of homemakers and personal care aides will increase by 119

Table 1

Unskilled Home Care Occupations

Occupation	Function	Level of Responsibility Description of Duties	Training Requirements
Home Care Aide I	Homemaker	Housekeeping and homemaking	40 hours of training
Home Care Aide II	Personal care aide	All Home Care Aides I responsibilities plus non-medically directed personal care	Home Care Aide I training with 20 additional hours
Home Care Aide III	Home health aide	All Home Care Aide II responsibilities plus some medically directed personal care	Home Care Aide II training with 15 additional hours
Home Care Aide IV	Home health specialist	All Home Care Aide III responsibilities plus developing a specialty	Home Care Aide III with additional hours (varies by specialty)

Source: Data from Massachusetts Council for Home Care Aide Services, "Home Care Aide I, II, and III Training Curriculum Outline," September 1995.

percent between 1994 and 2005 and that the number of home health aides will increase by 102 percent (from 420,000 to 848,000) for the same period.¹⁹

Home Care Aide IV, a new occupational level being developed by the Home Care Association of America and other industry advocates, is not yet being measured by Bureau of Labor Statistics data. The philosophy behind this level is to create home care specialties that offer these aides another rung on the career ladder and to provide better patient care. Many patients have particular illnesses for which specialists can furnish excellent treatment. Specialties are being developed in areas such as AIDS, pediatrics, Alzheimer's disease, and mental health.

Home Health Aides

The following discussion includes the results of several field interviews conducted over the course of three months with various employers of home health aides as well as trade associations for home health agencies.²⁰ These interviews reveal a mixed portfolio of opportunities for those in the occupation.

Home health aides (HHAs) provide daily living assistance to patients recovering from an ailment or the terminally ill who are living at home. The aides' activities include shopping, cooking and cleaning, and all aspects of general hygiene, including dental hygiene, bathing, and bedpan assistance. In addition, HHAs have several basic medical responsibilities: taking temperatures and pulses, changing simple dressings, and reminding patients to take prescribed medications. HHAs also assist in regularly moving bedridden patients to prevent bedsores and accompany ambulatory patients on trips outside the home. Considering that a substantial portion of the home care population is elderly, these activities are quite common.

The HHA range of care varies widely, depending on a patient's illness. HHAs usually follow a patient care plan prescribed by a doctor or an attending nurse. The degree of illness and the payment source dictate the amount of care a patient receives: some patients receive assistance for only a few hours a day, while others require around-the-clock attention.

Home health aides generally report to a primary nurse responsible for monitoring the medical condition of patients. As a result, a fundamental responsibility of the aide is to detect changes in a patient's condition and convey these to the nurse.²¹

HHAs fall into the general category of paraprofessionals within the health care industry. Other occupations in this grouping include nurse's assistants who work in a variety of settings, namely, nursing homes, hospitals, assisted living facilities, and home care agencies. Paraprofessional jobs are generally characterized by low wages, few benefits, minimal training, and restricted opportunities for career advancement.

Home Health Aides: Who Are They?

The employers I interviewed reported that home health aides were overwhelmingly young minority females for whom this job was often the sole source of income. The large number of women of color among the aides was probably a result of the fact that the agencies where I conducted interviews were located in the Boston metropolitan area. Industry representatives and employers outside the city suggested that home health aides in suburban and rural settings were older and "whiter" than their urban counterparts.

Surprisingly, the agencies reported that immigrants comprised a substantial portion of their workforce. Their rationale for this phenomenon varied widely, but many attributed it to the strong, informal networks within immigrant communities. Some employers maintained that immigrants were better educated, so it was relatively easy for them to become home health aides, while others claimed that it was a factor of immigrants' strong work ethic. This view implied that Americans were often unwilling to undertake the hard work necessary to become an HHA, an attitude that served as the largest barrier to employment.

Employers noted that while there were many immigrant HHAs, the countries from which they hailed differed from year to year. The latest contingent came from Africa, particularly Namibia, Uganda, Ghana, and Nigeria. However, there have also been waves of Haitians and Jamaicans from the Caribbean and Irish and various eastern Europeans. Finally, employers reported that increasing numbers of immigrant men were becoming HHAs, most of whom were working their way through school.

Employers acknowledged that HHAs generally had a limited amount of education, which coincides with the job's minimal education requirement. Although they do not need a high school diploma, HHAs must be certified. According to Penny Hollander Feldman's 1988 survey of 1,200 HHAs nationwide, their median education was twelve years, but 39 percent had not completed high school while another 40 percent had only a twelfth-grade education. Feldman also discovered that 65 percent of the HHAs were the primary caretakers in their families.

Other demographic variables from Feldman's survey confirmed my data. Feldman found that 98 percent of respondents were female, 49 percent were black, and 7 percent were classified as Hispanic. Roughly two-thirds, 65 percent, said that they were the primary wage earner in their household. The only inconsistency was in age, which in

Feldman's survey was a median of forty-five years, while most of the people I interviewed described their employees as young women. But perhaps even more important, many employers indicated that their employees were mothers whose parental skills were useful in their caretaking work.

Training and Recruitment

The minimal training requirements to become a home health aide should, theoretically, make the occupation accessible to a large number of former welfare recipients. HHAs need neither a high school nor a general equivalency diploma (GED). Instead, they must demonstrate proficiency in writing English, participate in a seventy-five-hour training program, pass a written examination, and demonstrate the requisite skills to be certified learning to keep their certification current.

A number of Boston area agencies offer training for HHAs, but the key agency for such certification is the Red Cross of Boston, whose home health aide class is the least demanding of its training programs. In addition, Red Cross training is available for health care assistant, a fourteen-week integrated education and training program, as well as nurse assistant/home health aide, a hundred-hour dual certification course. Instruction for the latter is focused on teaching students about basic care for patients in a home environment, in long-term facilities, and in hospitals. The program balances classroom and clinical experience, the first three weeks taking place in the former and the last week in the latter. Students who complete the course must register for state certification. Although the undertaking is short and rigorous, participants receive little assistance in securing jobs.

Since demand for Red Cross home health care training is very high, its programs are offered at three greater Boston sites; the Boston site offers new classes every week. Each new average class has twenty to twenty-four participants and an attrition rate of approximately 20 percent. Program staff claim that the high demand reflects the growth in the occupation, while the high turnover results from the grueling nature of the work.

Demographically, the majority of the participants in the Red Cross home health aide training program are immigrants, while roughly 30 percent are native-born Americans. Staff members believe that their backgrounds make a difference in participants' success. For example African immigrants, approximately 20 percent of trainees, tend to be better educated and do not encounter the same difficulties in taking the reading comprehension test as their Haitian counterparts, who account for about 50 percent of the program population. Similarly, the Africans have better verbal skills. While most immigrant groups tend to have extensive familial networks that allow them to balance the demands of the program against personal, usually family, commitments, this does not appear to be true of African-American and Hispanic-American trainees.

The great demand for HHA training seems, to some extent, to be stimulated by the high turnover and churning that occurs within the field, which is characteristic of much low-skill work.²² While there is no systematic collection of information regarding turnover in the field, employers report length of tenure for aides in a range from a few months — in some instances a few weeks — to as many as fourteen years. All employers reported a consistently high turnover rate, which most attributed to the aides' constant search for marginally better wages. Comparatively low wages and minimal benefits obviously do not provide enough incentive to keep most people employed for the long term despite the intense demand for home health services.

Working Conditions in Home Care

According to employers, home health aides most often cite inadequate wages as the reason for leaving their current agency to work for another, or for leaving the industry altogether. However, my interviews suggested that factors besides wages play a large role in the decision of aides to leave their employers. The following issues offer some clues to turnover and attrition.

Hours. Scheduling is often regarded as a home health agency's most difficult task. The scheduler is responsible for matching the demands of clients to the available aides while ensuring that aides have employment for the number of hours promised to them each week — not an easy task.

Few HHAs work a traditional forty-hour week. While there are no figures to indicate how many hours per week, on average, most of them work, employers estimate that roughly 10 percent are employed full time.

The high incidence of part-time work results from the intense demand for care at two peak periods. Patients want assistance during the morning hours to help them in bathing and dressing and during the evening hours for cooking their dinner and preparing them for bed. Few patients receive around-the-clock assistance or need an aide during midday hours. This pattern leads to part-time work for most aides.

Home care aides represent just one occupation among the many that make up the new involuntary contingent workforce. According to Chris Tilly, employers within the service industry use part-time and contingent workers as a means to cut wages, keep benefits low, and maintain staffing flexibility, and the flexibility requirement drives the industry's demand for contingent and part-time workers, even though most of the aides would prefer full-time employment. Tilly claims that a contingent workforce often results in firms' decline in productivity owing to the ensuing high turnover, the low skill base of workers, and lack of job commitment.²³ Furthermore, he argues that part-time and interim work disproportionately affects those who find it difficult to form a labor-market attachment, especially women, people of color, and youths.²⁴

Wages. Since the 1960s, when home care was first introduced as an alternative to institutional health care, wages for home health aides have been low. One respondent suggested that home health care is really the "negative side of charity." Prior to formal home care, aides' tasks were assumed by neighbors and friends and churches as a charitable contribution. Preparing a meal and cleaning someone's home was part of being a good neighbor and an active citizen. Once it became a component of the formal labor market, the work was undervalued and consequently underpaid.

Wages in this field are notoriously low, even in a state with a tight labor market, like Massachusetts, in which one would expect to find higher compensation. Table 2 shows the wage rate for HHAs compiled for *Home Health Line*, a trade magazine. As part of an effort to standardize wages within the industry, in the early 1980s the Massachusetts Council for Home Care Aide Services undertook a campaign to establish its minimum wage standards. The success of that effort means that today a home health aide's minimum wage should be \$7.93, while the average wage should be \$8.20. (These figures include employers' cost of benefits, so the aides may be earning less than these hourly amounts.) Most employers pay a dollar-per-hour bonus for weekends and time and a half for holidays. My interviewees revealed that while selected agencies offered wages above this range, many more paid less than the minimum. Wages have been frozen at

this level since 1990, and the Massachusetts Council for Home Care Aide Services, with other advocates, is lobbying to support an increase of up to 4 percent for workers earning less than \$20,000 annually.

Gathering accurate wage data in this field is difficult. Data from multiple sources revealed that wages were as low as \$4.75 per hour and as high as \$15.04 per hour. These data vary, depending on whether an aide is certified, whether the aide is employed by a public or a private agency, the aide’s years of experience, the number of years an aide has been with a particular firm. The data I present here are based on a survey conducted by the Massachusetts Department of Employment and Training.²⁵

The importance of understanding these wage rates is underscored in a study by Kathryn Edin, which surveyed the incomes and expenses of 214 AFDC recipients and 165 low-wage, single, working mothers in Cambridge, Massachusetts, San Antonio,

Table 2

Average Hourly Wage for Home Care Aides, by Region

Wage Level	Pacific	Mountain	W. North Central	E. North Central	South Central	New Mid-Atlantic	South Atlantic	New England
High	\$10.09	\$8.48	\$8.56	\$7.60	\$8.57	\$8.28	\$8.12	\$10.13
Low	\$8.26	\$6.46	\$6.67	\$6.11	\$6.44	\$6.74	\$6.79	\$7.64

Source: Based on a report by Marion Merrill Dow, Managed Care Digest Series, *Institutional Digest*, 1995; original data from SMG Marketing Group Inc. (adapted from *Home Health Line* magazine).

Texas, Chicago, Illinois, and Charleston, South Carolina. She shows that an increase a working mother receives in her low-paying job is canceled out by the increase in her monthly expenditures for rent, clothing, child care, transportation costs, and so forth.²⁶ Edin’s study showed that such expenses increased by nearly 30 percent (see Table 3). Thus, for low-wage workers in Edin’s study, disposable income increased by only \$5.00 per month. If we apply the wage rates for home health aides to various hourly work arrangements, we get the monthly income estimates shown in Table 4. Based on Edin’s expenditure data, only full-time aides earning the highest possible entry-level pay of \$9.00 per hour would be able to meet their expenses.

Benefits. Home health aides do not receive any standard benefits. Benefit packages varied widely by firm, and premiums were usually awarded only to full-time employees. Packages could include any combination of three categories of benefits: health and disability insurance, travel reimbursement, and time off. Because the packages varied tremendously, the best-case scenario offers perhaps the most candid look at how benefits are distributed. The employer in my sample who offered the most generous package first stratified his employees by the number of hours worked. Table 5 gives its details. Its implications are twofold. First, since “full-time” positions are almost always awarded to those with the most seniority, welfare mothers entering the occupation can expect to receive scant benefits. Second, with only 10 percent of the industry working what is traditionally considered a full-time schedule, very few aides would be eligible for them.

Table 3

Income and Expenses for Welfare Recipients versus Low-wage Workers

	Welfare Mothers	Low-Wage Working Mothers
Total Expenses	\$876.00	\$1,237.00
Total Income	\$892.00	\$1,258.00
Differential	\$16.00	\$21.00

Source: Adapted from Kathryn Edin, "The Myths of Dependence and Self-sufficiency: Women, Welfare, and Low-wage Work," Working Paper No. 67 (New Brunswick, N.J.: Center for Urban Policy, 1994), 1.

There is considerable debate regarding the necessity of providing HHAs with health insurance. According to the Massachusetts Council for Home Care Services, most aides indicate that, given the choice, they would prefer cash to health insurance, for which the council cites two explanations. First, HHAs coming from welfare are generally covered by Medicaid for up to a year, so in the interim they would rather have the cash. Second, aides are covered by a spouse's insurance, which is a more likely scenario in suburban and rural areas where home health care workers' wages provide supplementary family income. An interview with one employer who services suburban communities confirmed this hypothesis.

The industry has no standards concerning reimbursement and remuneration for HHAs who travel. This is significant, since most aides see more than one client daily and many depend on public transportation. Since there is no norm covering payment for travel time and expenses, policies vary widely. The firms I interviewed ranged from contributing nothing to as much as \$35 per week for travel stipends.

Table 4

Four-week Wage Estimates for Entry-level Home Health Aides, Boston Metropolitan Statistical Area

Wages	20 hours/week	Part-time 25 hours/week	30-hours/week	Full-time 35 hours/week
\$9.00 (high)	\$720.00	\$900.00	\$1,080.00	\$1,260.00
\$7.93 (median)	\$634.00	\$793.00	\$952.00	\$1,110.00
\$7.05 (mean)	\$564.00	\$705.00	\$846.00	\$987.00
\$4.75 (low)	\$380.00	\$475.00	\$570.00	\$665.00

Source: Commonwealth of Massachusetts, Division of Employment and Training, "1996 Occupational Wage Survey," November 29, 1996, by Metropolitan Statistical Area.

Working Conditions. Working conditions contribute significantly to the low retention rates of home health aides. Since they almost always work alone, the aides are physically and emotionally isolated in their jobs.²⁷ This situation is compounded by the fact that HHAs are often assigned to the acutely and terminally ill in an environment that is emotionally and physically demanding. Because aides must learn to deal regularly with death and grief, their training includes a component entitled “Loss and Grief, Death and Dying.”²⁸ When patients die, aides may often be left without a regular client for an extended period, which raises questions about the degree of job security.

Despite HHAs’ low wages and minimal benefits, scholars and policymakers have suggested that there are other advantages to be reaped by most neophytes entering this workforce. One theory is that newly employed entrants in the labor market have a short tenure in their first job as they become accustomed to the norms of work and the workplace. Employers, who believe they are essentially being asked to absorb the cost of making such workers “job ready” while receiving little in return, are usually reluctant to hire them. Nevertheless, many new aides move on to a new job after a short time. The question is, What kinds of jobs might these workers be prepared for in their next assignment? In particular, what employment opportunities and career trajectory are available to a home health aide?

Table 5

Benefit Package for Home Health Aides, Best-case Scenario

	30 hours/week or more	20 hours/week or more	19 hours/week or less
\$100 cash allowance toward health insurance	•		
6 paid holidays/year	• ^a	• ^b	
Free life insurance and long- and short- term disability	•		
One-week paid vacation	•		
\$0.20 per hour travel reimbursement	•	•	•
Physical examination on hiring	•	•	•

^aBased on an eight-hour day.

^bBased on a four-hour day.

The Challenge of Advancement

The literature points to three predominant barriers to promotion for low-income workers to high-paying, higher-status jobs: (1) employee deficiencies, (2) employer deficiencies, and (3) structural hindrances.

Barriers to Promotion and Advancement

A key barrier to job advancement is employees' lack of appropriate skills and training for better jobs. These may range from a lack of such basic abilities as core competency in English, mathematics, and other subjects and inadequate language familiarity to a lack of training in a particular occupation.²⁹ Studies show that low-income people are often wanting in basic and occupational skills and suggest that these deficiencies serve as barriers to their continued career advancement. Generally speaking, both welfare recipients and home health aides may possess inappropriate know-how. Feldman discovered that as many as 80 percent of her sample had never been exposed to post-secondary education.³⁰

The second barrier to job advancement pertains to the failure of employers to promote low-income workers, for which there are several reasons. For example, there may generally be little job mobility regardless of level of earnings. One school of thought faults employers for not providing on-the-job training and other opportunities for workers to upgrade their skills. This premise has gained currency in light of theories claiming that improved technological innovations have resulted in firms' de-skilling work.³¹ Finally, low-income workers' absence of job mobility may stem from employers' attitudes toward and perceptions of minimum earners. Studies have shown that many bosses practice statistical discrimination, judging potential employees on the basis of unreliable data such as race, gender, ethnicity, address, surname, and primary language. These frequently prevent managers from determining candidates' qualifications for positions.³²

My study found that employers were partly responsible for the paucity of HHA job mobility. Many reported that their agencies offered only a few positions that paid higher wages and benefits, so it was often impossible to reward good aides because such premiums were unavailable. It is also true that there are few opportunities for improving skills. Since most HHAs work independently, they have no mentors who can teach them or expose them to new knowledge pertaining to the job.

There is no doubt that employers judge aides on the basis of irrelevant data. Some indicated that former welfare recipients immediately "raised a red flag," particularly in relation to their qualifications as potential aides. Many more said, "You can't change attitudes" and voiced the opinion that many HHAs simply had no motivation to become upwardly mobile, rendering the issue of advancement and promotion irrelevant.

Finally, the immobility of low-income workers may be structural, resulting from a firm's internal and external institutional barriers. For example, the failure to hire may reflect the paucity of career ladders developed for low-wage positions. It could also be laid at the door of labor unions for their failure to involve the workers in a union, to organize these poorly paid workers, and to display a strong union presence. Institutional barriers may also result from the level of government involvement, for example, in policies that provide disincentives for promoting workers or in providing regulation of practices that exist through nothing but the invisible hand of the free market.

There is no doubt that structural barriers pose the greatest challenge to job advancement for low-income workers. Simply put, home health aides can't move up because

there is no place for them to go. Most employers with whom I spoke indicated that there is no such thing as promotion for an HHA. Advancement is accomplished in one of four ways: (1) an HHA leaves a firm in search of better wages and, to a lesser extent, benefits; (2) after working for a number of years, an HHA is hired for a full-time position; (3) again after many years, an HHA becomes a preceptor or specialist; and (4) an HHA moves into an administrative position within a firm.³³ The last three alternatives suggest the possibility of a career ladder, but so few positions become available that these options hardly constitute a mechanism for advancement.

Efforts to develop a more articulated career progression are being thwarted by larger institutional and structural barriers. Industry advocates, who are only beginning to develop specialties as a means to HHAs' upward mobility, are finding that market acts as the largest disincentive. The federal government, the major purchaser of home care services through Medicare and Medicaid, reimburses home care agencies for providing services at a set fee. Since these rates are not adjustable for those who develop specialties, a certified agency wishing to reward employees must pay out of pocket the training costs and wage premiums for aides' additional skills. This suggests that private agencies, which can pass costs directly to their clients, might be more likely to go this route.

Managed care also makes it difficult to upgrade home health workers' skills. While managed care executives support HHAs' assignment to additional responsibilities as a less expensive alternative to employing health care professionals for such duties, they are unwilling to pay for such services. Those organizations' philosophy is to pay for immediate, not long-term care. Therefore, while demand for home health aides appears to be strong, the impact of managed care may prove that it is overstated because clients are receiving only short-term care. There may be evidence for this assertion. One respondent indicated that the length of hospital stays rose in 1996 for the first time since the early 1980s.

Overall, this analysis suggests that HHAs' slim chances of internal promotion stem from the lack of an internal labor market that could provide a career ladder for aides. Such markets have traditionally been instrumental in career advancement because they have "provided employment stability and paths within the firm along which workers could obtain training, improve job skills, and advance to higher levels of responsibility."³⁴ However, the analysis also indicates that the weak internal labor market is endemic to the part-time and contingent nature of home care. In sum, promotions are rare within the occupation, but this does not address the question of advancement outside it. Is it possible that employment in such low-wage jobs can have a positive effect in increasing labor-force attachment overall so that workers leave the field to take higher-wage positions? Katherine Newman, who examines labor-market opportunities in the fast-food industry, claims that there is no way to ascertain whether greater labor-force attachment results without following longitudinally those who exit the occupation.³⁵ The topic provides an area for further research.

Public Policy Implications and Prescriptions

This research has important implications for the success of Temporary Assistance for Needy Families, which has linked welfare to employment. Strategies have usually focused on enabling the poor to gain access to jobs, for example, through mobility programs like Gatreux and Moving-to-Opportunity, as well as improving the skills of the poor through employment training. Most such efforts attempt to furnish unskilled

workers with appropriate qualifications for specific jobs, yet my research suggests that skills may not be enough to keep workers from becoming part of a secondary labor market in which they remain poor. The perversities of this policy are well outlined by economist Rebecca Blank, who argues that while welfare reform is intended to be a response to poverty, that is, an antipoverty measure, the policies set forth in the new legislation are in fact part and parcel of an employment strategy designed to put people to work regardless of whether it succeeds in lifting them from poverty.³⁶

The foregoing analysis indicates that despite the projected increase in demand for its services, the concept of the home health aide occupation as a stable source of employment for welfare recipients should be viewed with skepticism. However, possible interventions requiring action by major institutions could be introduced to improve the labor-market situation for would-be home health workers. The first, most far-reaching response would be for the federal government to rethink the creation of a comprehensive social safety net. Such an instrument, premised on basic rights rather than on poverty status, could improve the lives of all Americans dramatically. In particular, universal health care and national child care would remove many of the barriers women leaving welfare and entering the labor markets will face and offer tremendous assistance to the working poor.

In addition to prescriptions, which help the working and nonworking poor, the government could provide antidotes to affect the home health industry. Through Medicare and Medicaid, the government has a unique degree of latitude in changing the conditions under which most HHAs work. Premium pay for home care specialists could help to build a career ladder and improve HHAs' wage rates. Other means of career ladder development require the combined efforts of government, industry, and labor, which could work together to reexamine the frame for advancement within the health delivery sector and determine how to change home health aide from a "terminal" to a "gateway" occupation. It has been proposed, for example, that there is a large gap in the occupational structure of low-income home health aides and nurse assistants, who are paid roughly \$8.00 an hour, and vocational nurses, LPNs, who are paid roughly \$18.00 an hour. In addition, the large divide in skills required for these occupations must be narrowed.

Finally, employers, fearing that they may have to absorb the cost of making them job-ready, are reluctant to hire welfare recipients as home health aides. This suggests a role for intermediary institutions that specialize in job preparation and offer post-placement support to their program participants. Project STRIVE furnishes a useful model in this area, offering four weeks of "boot camp" job training followed by assistance with job searches and ongoing support during the first six to twelve months of employment. Home care will be a principal focus of the organization's Boston office. The help of such groups will be necessary to facilitate the transition between welfare and work.

U.S. poverty is measured in absolute terms, that is, against an official government standard which dictates a minimum standard of living.³⁷ The Temporary Assistance for Needy Families legislation attempts to solve the problem of poverty by time-limiting welfare and mandating that recipients find work. However, if, as this study suggests, working people remain poor, perhaps our standard of poverty ought to be measured in relative terms, that is, against the standard of living of society as a whole.³⁸ Poverty in this case is an issue of increasing inequality, particularly for the working poor, helping to explain why its level has not abated despite a tremendous growth in national income.³⁹

Nevertheless, the economic realities of the labor market are hard to ignore. Nation-wide a growing supply of less educated workers compares with a high demand for more educated workers, and the home care industry is undoubtedly not immune from these trends. While the effects in Massachusetts are more muted because of the comparatively tight labor markets, there is every reason to believe that the overall outlook for home health aides is more positive in this state than in others.

The dual labor markets characteristic of the health care industry raise fundamental questions about issues of equity and the distribution of income within American society. Economist Paul Krugman describes the postwar boom years as a “picket fence” in which economic growth meant relatively equal growth for all subgroups within the population, but the rising tide has not lifted all the boats. These trends have changed. “Growth in the 1980s,” Krugman claimed, “looked like an American staircase, with the well-off at the top step.”⁴⁰ Those on the bottom step are trapped in a cycle of poverty. This offends our American ideal of equity and has ramifications for the ability of individuals to engage fully in the political, social, and economic life on which American society is based.

Ultimately, the story of employment in the health care industry is one of good jobs, bad jobs, and equity. The fact of the matter is that employment shifts in the health care industry will have a disproportionate impact on those with the least number of skills and resources and consequently the least ability to rebound from these changes. The eternal question remains: What, if anything, are we willing to do about it? ♿

Notes

1. Kathryn Edin, “The Myths of Dependence and Self-sufficiency: Women, Welfare, and Low-Wage Work,” Working Paper No. 67 (New Brunswick, N.J.: Center for Urban Policy Research, 1994) 39.
2. Rebecca Blank, “Policy Watch: Proposals for Time-Limited Welfare,” *Journal of Economic Perspectives* 8, no. 4 (Fall 1994): 187.
3. Edin, “The Myths of Dependence and Self-sufficiency,” 18.
4. Newman offers the following regarding the prevalence of employment within the fast-food industry: “One in 15 Americans working today found their first job at McDonald’s — not including Burger King and the rest.” Amazing! Katherine Newman and Chauncy Lennon, “The Job Ghetto,” *American Prospect*, no. 22 (Summer 1995): 66–67.
5. *Ibid.*, 67.
6. *Ibid.*
7. Katherine S. Newman, “Dead-End Jobs, A Way Out: Improving Job Mobility in the Inner City,” *Brookings Review* 13, no. 4 (Fall 1995): 25, and Katherine Newman and Chauncy Lennon. “Finding Work in the Inner City: How Hard Is It Now? How Hard Will It Be for AFDC Recipients?” Working Paper #76 (New York: Russell Sage Foundation, October 1995), 9.
8. Newman, “Dead End Jobs,” 24.
9. Commonwealth of Massachusetts, *Choosing to Compete: A Statewide Strategy for Job Creation and Economic Growth*, Department of Economic Development: <http://www.magnet.state.ma.us/econ/toc.htm>, May 1993, Chapter 13.
10. Jerome H. Grossman and Suzie A. Blevins, “An Update on the Massachusetts Health Care Industry,” conducted by the Task Force on the Health Care Industry and Governor’s Council on Economic Growth and Technology, July 1995, 32.
11. Andrés Torres, “Conference Remarks,” in *The Ongoing Revolution in Health Care: What It Means for the New England Economy*, summary of Conference Proceedings, May 1994, edited by Jane Sneddon Little and Rebecca Hellerstein (Boston: Federal Reserve

- Bank, May 1995), 34, and Bette Woody, *Black Women in the Workplace* (New York: Greenwood Press, 1992), 81.
12. Economic Development and Industrial Corporation, "The Missing Rung: A Study of Career Opportunities for Boston Residents in Boston Hospitals and Long Term Care Facilities" (EDIC: April 1992), and Jane Sneddon Little, "Health Care Reform in the New England Economy," in *The Ongoing Revolution in Health Care*, 12.
 13. To date, the most comprehensive survey of home care labor-market conditions was conducted by Penny Hollander Feldman. Her study, "Who Cares for Them? Workers, Work Life Problems, and Reforms in the Home Care Industry," October 1988, examined the labor-market, workforce, and industry conditions for the home care industry, complete with a 1,200-person survey of home care aides in five cities. She also found that home care was being substituted for institutional care, resulting in home care workers' subsidizing the cost of care. Furthermore, she asserted that poor and elderly women were disproportionately affected by these shifts: both populations had low incomes and undesirable household situations, poor women because they were single parents and older women because they lived alone.
 14. To apply these authors' typology to health care, the primary labor market has doctors and nurses in one tier and skilled technicians, for example, respiratory therapists, in another, while the secondary labor market separates office and secretarial workers from maintenance and service staff.
 15. Peter B. Doeringer and Michael Piore, *Internal Labor Markets and Manpower Analysis* (Lexington, Mass.: Heath Lexington Books, 1971), 166.
 16. Ibid.
 17. Michael Piore, "On the Technological Foundations of Economic Dualism," Working Paper #110, Department of Economics (Cambridge: MIT, 1973).
 18. Bennett Harrison, *Lean and Mean* (New York: Basic Books, 1995), 220.
 19. Bureau of Labor Statistics, "Fastest Growing Occupations," Office of Employment Projections, November 1995: <http://stats.bls.gov/emptab1.htm>, April 2, 1996.
 20. I conducted in-depth interviews with a small sample of Boston metropolitan area employers responsible for hiring and promotion decisions to gain an understanding of the overall structure of the home health care subsector and identify the barriers that prevent executives from promoting low-wage workers to higher-paying occupations. I asked employers about hiring and job advancement for home health aides. The interviews included questions regarding the types of entry-level jobs, requirements for those jobs, recruitment strategies, wages and benefits, career ladders for entry-level positions, opportunities for on-the-job training, opportunities for and barriers to promotion and advancement, and finally, demographic information regarding the makeup of the organization and that of the entry level workforce. I identified respondents through purposive and snowball sampling techniques, conducting interviews in a variety of institutional settings to better understand the areas of similarity and divergence among different types of firms. I was particularly concerned with including privately held organizations in the sample. Of a total eight in-depth interviews, the sample included three nonprofit home health agencies, three for-profit home health agencies, and two employer trade associations. I conducted all the interviews with employers and staff between August and October of 1996. As a rule of thumb, I spoke with the highest ranking individual in the firm to whom I had access, usually the president or executive director and occasionally a knowledgeable staff member. Each interview lasted sixty to ninety minutes.
 21. The role of the supervising nurse depends on how an agency is reimbursed for treatment. If public dollars are used, care is given through a certified agency and the nurse is required to evaluate the patient every two weeks. If the patient is responsible for payment, care is given by a noncertified agency whose nurse conducts an orientation visit in the home and monitors and supervises the employee every three months.
 22. Newman, "Dead End Jobs."
 23. Chris Tilly, "Short Hours, Short Shrift: The Causes and Consequences of Part-time Employment," in *New Policies for the Part-time and Contingent Workforce*, ed. Virginia duRivage (Armonk, N.Y.: M. E. Sharpe, 1992), 15-44.
 24. Ibid.

25. These data were based on surveys of 23 firms, representing 1,245 workers, in the Boston metropolitan statistical area, which were conducted between October 1995 and June 1996. Commonwealth of Massachusetts, Division of Employment and Training, "1996 Occupational Wage Survey," <http://www.magnet.state.ma.us/det/lmi/wages/intrvwage.txt>, November 29, 1996.
26. Edin, "The Myths of Dependence and Self-sufficiency," 15.
27. Feldman, "Who Cares for Them?" 92, found that loneliness was a significant determinant of attrition, as was the level of satisfaction with pay and benefits.
28. Massachusetts Council for Home Care Aide Services, "Home Care Aide I, II, and III Training Curriculum Outline," September 1995, 11.
29. Richard Murnane and Frank Levy, *Teaching the New Basic Skills: Principles for Educating Children to Thrive in a Changing Economy* (New York: Free Press, 1996).
30. Feldman, "Who Cares for Them?" 75.
31. Paul Osterman, "Gains from Growth? The Impact of Full Employment on Poverty in Boston," in *The Urban Underclass*, edited by Christopher Jencks and Paul E. Peterson (Washington, D.C.: Brookings Institution, 1991), 122-134.
32. Joleen Kirschenman and Kathryn Neckerman, "'We'd Love to Hire Them But . . .': The Meaning of Race for Employers," in *The Urban Underclass*, 204-217, and William Julius Wilson, *When Work Disappears: The World of the New Urban Poor* (New York: Knopf, 1996), 136-137.
33. Employers consistently believed it was highly unlikely that home health aides would become LPNs and R.N.'s. Their reasoning was that HHAs could not afford the time and expense of additional training.
34. Eileen Appelbaum, "Structural Change and the Growth of Part-time and Temporary Employment," in *New Policies for the Part-time and Contingent Workforce*, 6.
35. Newman, personal communication, 1996.
36. Blank, "Policy Watch," 192.
37. Lee Rainwater, "A Primer on American Poverty: 1949-1992," Working Paper #53 (New York: Russell Sage Foundation, May 1994).
38. Lee Rainwater, "Poverty in American Eyes," Luxembourg Income Study, CEPS/INSTEAD, October 1991.
39. Rainwater, "A Primer on American Poverty," and Paul Krugman, *Peddling Prosperity* (New York: W. W. Norton, 1994).
40. Krugman, *Peddling Prosperity*, 132.