

Testimony before the Connecticut State Human Services Committee Hearing on ...

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My name is Candace Howes. I am a Professor of Economics at Connecticut College where I have been employed since 1995. I teach labor economics and econometrics (statistics applied to economic problems). Prior to this appointment, I was an Assistant Professor at the Notre Dame University in the Department of Economics for four years. I am also a member of the Working Group on Care, funded by the Russell Sage Foundation. Under the auspices of the Russell Sage Foundation, the group has recently completed a book on care workers, including long term care workers, which we expect to see published in 2012. In 2004-2005, I was the Principal Investigator on a project funded by the Robert Wood Johnson Foundation and Atlantic Philanthropies, the purpose of which was to examine the effect of wage and benefit variation on recruitment and retention of consumer-directed homecare workers in the IHSS program in California. Some of the results from that Better Jobs, Better Care project will be reported here today. I have published results from that project, in *Industrial Relations* and *The State of California Labor*, both of which are published by the University of California, and in *The Gerontologist*. Several other pieces are currently forthcoming or under view in academic journals. I have also served as an expert witness in a class action suit that was brought by consumers and providers against the State of California. In the first round, the state was enjoined from cutting the wages for IHSS workers on the grounds that the state had not effectively shown that there would be no irreparable harm to consumers, a violation of Medicaid rules. I hold a Ph.D. in Economics from the University of California, Berkeley and did a post-doctoral fellowship in the Program on Regional and Industrial Economics at Rutgers University. A copy of my curriculum vita is attached.

I have been asked by SEIU to report on the findings of my research on the consumer-directed home care program in California and the relevance of those findings to the council under consideration at this time in the General Assembly of Connecticut, as described in RB No. 6486.

In this extended testimony to be submitted to the record, I will report the results of my research on the personal care assistant program in California, known as In-Home Supportive Services (IHSS). IHSS is organized under a quasi-public entity, known as a "public authority," which is similar to the council being proposed for Connecticut. My research suggests that, subsequent to the establishment of public authorities in California, the conditions of employment for workers and the quality of care improved.

California runs the largest consumer directed personal care assistance program in the world. Under the California program, which is primarily paid for by the Medicaid Personal Care Option combined with a Medicaid waiver, nearly 450,000 consumers receive an average of 100 hours of care per month – or 25 hours per week - in their homes. In California, 13.8 persons per 1000 in the population were enrolled in Medicaid long term care programs in 2006, close to Connecticut's 15.0 per thousand in the same year (Howes 2010). Two thirds or 9.6 per thousand were enrolled in the IHSS program, while 4.2 per thousand received long term care in nursing homes. The per capita cost to state and federal tax payers was \$210, in contrast to Connecticut's per capita cost of \$392. Much of the per capita cost difference can be explained by Connecticut's greater reliance on nursing homes where 11.2 persons per thousand received Medicaid long term care services. Only 4.8 Connecticut residents received Medicaid long term care services through home and community-based services.

As in other states, demand for homecare services in Connecticut is expected to continue to grow rapidly in the coming years, but also, like other states, Connecticut faces a problem of recruiting sufficient numbers of workers to perform these jobs. Based on an analysis of the Current Population Survey, homecare workers were found to be, nation-wide in 2010, among the poorest compensated

workers. Their average wage was \$9.50 an hour. One third of PCAs did not have any form of medical insurance, and one third were getting their health care insurance through Medicaid. PCAs have high occupational injury rates, low job satisfaction and high turnover rates. Researchers have estimated that between 40 and 60 percent of PCAs leave their jobs each year, meaning consumers must on average find a new provider every six months. Unless the quality of the jobs can be improved and the workforce stabilized, consumers will face risks as the demand for homecare services, and especially for consumer-directed home care, grows.

There are currently three ways to organize consumer-directed home care in the U.S. Already wide-spread in most states are agency-organized homecare services. To some extent, components of consumer direction can be added to this model. Often consumers do not have a choice of provider, the work tends to be organized as short bursts of service and the cost of agency-directed care is about twice that of consumer-directed care. Under the Cash and Counseling demonstration grants, states have experimented with paying cash directly to consumers. The payments can be used to purchase home care services, house-keeping services, and assistive technology and to make modifications to the home.

The third system, in which a public entity acts as the employer of record for homecare providers who are hired by consumers but paid by the state or other third party, is commonly known as the public authority model. California, among other states with public authorities demonstrates the advantages both to the consumers and the workers of having a public entity that can serve as the employer of record, provide training for consumers and workers, and organize worker registries.

The results of my research suggest that public authorities improve the quality of the jobs and the stability of the workforce:

- Personal care assistants in California are demographically similar to PCAs in other parts of the country in terms of age, gender and level of education;
- But, their average wage rate is somewhat higher than the national wage rate for PCAs;

- California IHSS workers are less likely to be on public assistance, they are half as likely to be uninsured, half as likely to be getting public insurance and 50 percent more likely to have employer-based health insurance than PCAs nation-wide;
- Their turnover rate at 25 percent is half the average of homecare workers nation-wide and they are half as likely to be planning to leave the job within 2 years. Other studies have found that about one-third of PCAs intend to leave within one year, and 47 percent within two years, whereas only 6 percent of IHSS workers report such intent;
- Finally, the pool of labor in one county where home care workers were eligible for health insurance, even when they worked as few as 35 hours per week, grew at twice the rate of the labor pool, state-wide; this was because workers in other low wage occupations and family caregivers began to see homecare as a good alternative to their jobs as clerks, factory workers, maids, house-keepers, childcare workers and food service workers;

In addition, to improving the quality of the job:

- Public authorities frequently provide training to consumers and providers;
- California public authorities have organized respite care and emergency services;
- California public authorizes maintain a registry of qualified workers.

The public authority increases the likelihood that workers will get basic labor protections and that they will not retreat into the gray market where they are unlikely to pay taxes and where the employer is unlikely to make social security contributions or pay workers' compensation.

In the extended testimony that follows here, and which is to be submitted to the record, I provide documentation of my own and other research that supports these claims.

## The home health care and home care industries - problems of recruitment & retention

The formal sector for home health care and home care includes Medicare- and Medicaid-certified home health care companies that supply services ranging from skilled nursing services, home health care, and personal care services to durable medical equipment. Some for-profit chains and smaller proprietary and non-proprietary firms limit their services to non-medical, limited personal care and homemaking.

Increasingly though, individuals are paid by state-level public authorities to provide personal care to Medicaid recipients. Under this model, which originated in California, workers are paid by the state to provide Medicaid-funded personal care services to Medicaid recipients. The care recipients take responsibility for hiring and supervising the workers, but the public authorities are their employers of record, which allows the workers to join unions, bargain collectively, and access group benefits such as worker's compensation and health care benefits.<sup>1</sup> Including California, where there are now over 350,000 independent providers, 11 states now provide Medicaid personal care services under this model of "consumer-directed" care. Many states have begun to test other models for administering consumer-directed programs under the auspices of government-funded demonstration projects, such as Cash & Counseling. Under Cash & Counseling consumers are given a cash allowance that can be used to purchase homecare and other services, to purchase assistive devices or make modifications to their homes.

Other home care providers work as independent contractors, either declaring self-employment or working under the table. As with child care workers, the number of independent home care workers who provide care off the books may be considerably higher than reports based on the Current Population Survey suggest.

Consumer preferences combined with demographic trends help account for the very high rate of projected job growth in the home health and home care industries. Between 1989 and 2004, the

work force providing non-institutional personal assistance and home health services tripled while the workforce providing similar services in institutional settings remained relatively stable (Kaye et al. 2006). Home health care and services for the elderly and persons with disabilities (home care) are the industries with the 3<sup>rd</sup> and 4<sup>th</sup> fastest rate of growth of employment in the United States. Together, adult or long-term care industries, which made up about 3 percent of all jobs in 2008, are projected to account for 10 percent of all expected new jobs between 2008 and 2018. Two-thirds of these jobs will be in home health and home care (BLS 2010).<sup>ii</sup>

### Home health and home care workers (personal care assistants or aides)

Home health aides are employed mainly through Medicare-certified home health care agencies, and much of the care they provide is financed by Medicare or Medicaid. Personal care aides perform the same functions as nursing assistants, but in homes and non-medical residential care facilities. An analysis of the Current Population Survey indicates that about one-third of personal care assistants are employed by home health agencies and another third by home care companies, and the rest work as independent providers in private households.

Policy makers in many states have expressed doubts about their states' ability to fill the new openings for home care and home health care workers as they proliferate, concerned that low wages, poor working conditions, and a lack of affordable benefits will keep turnover rates high and fail to attract enough new workers. In a 2007 survey of states, 33 of the 34 respondents ranked "direct care" vacancies and/or turnover as a "serious" or "very serious" issue, which was a substantial increase from 2005 when only 76 percent of respondents indicated that this was a serious issue (PHI and Direct Care Workers Association of NC 2009). The abrupt increase in unemployment associated with the Great Recession may have temporarily allayed labor shortages, but has decreased the economic resources

available to pay for such services. In general, this labor market suffers from instabilities that make it difficult to promote sustainable and effective care.

### Characteristics of workers and jobs

Personal care assistants are drawn from the demographic of women who typically work in low wage jobs which require limited education and short term on the job training. For most, their options are limited to jobs in housekeeping, childcare, factories, food services and some low wage office or warehouse jobs as clerks. In 2010, PCAs were paid an average of \$9.50 per hour, according to an analysis of the Current Population Survey (Table 1). Fifty-eight percent worked full time; 14 percent worked more than one job, and 7 percent were self-employed. A third of all personal care assistants were enrolled in a public health insurance program, while 31 percent were uninsured. Their education levels are typical of workers in the bottom of the wage distribution: 55 percent have completed only high school or less; only 12 percent have a bachelor's degree. Twenty-three percent were foreign born; 37 percent had children under 18 and 23 percent were single mothers.

They work in jobs that are physically demanding. Nursing home aides, orderlies and attendants, for example, have the highest occupational injury rates of any workers in private industry (BLS 2006). Home care workers have been studied less than other paid caregivers, but their reported injury rate is three times that of registered nurses (Kim 2010). Unlike in nursing facilities, where regulations require that a second person be there to assist when an aide lifts a patient, home health and home care workers are expected to lift clients without assistance. Rarely does one find a mechanical lift in a private home (Muntaner 1999). The physical demands of the job contribute substantially to the risk of musculo-skeletal injury (Kim et al. 2010). Improved training and supervision has been shown to lower injury rates as well as reduce turnover (McCaughey et al. 2010).

Yet, training and licensing of home care workers is extremely limited and is very unlikely to occur outside of a formal employment relationship with an agency or a public authority. Certified nursing assistants and certified home health aides must receive 75 hours of federally mandated training. Some states have extended these requirements to as much as 175 hours. But, there are no federal training requirements for personal care assistants. As of 2007, however, six states – all of which provided some home care under a public authority model - had adopted training requirements for PCAs in consumer-directed programs (PHI 2009). As the Institute of Medicine puts it, “the education and training of the direct-care workforce is insufficient to prepare these workers to provide quality care to older adults” (IOM 2008: 204).

Like nursing home aides, home care workers tend to cycle in and out of different types of care jobs (including child care, as well as elder care), often even moving in and out of the labor force (Howes 2008). However, they are more likely to work part-time and to work for more than one agency or family at a time or to work at more than one job. These workers tend to enjoy more autonomy and discretion, but are prone to social isolation, difficulty juggling multiple employers, and time-consuming (and often uncompensated) travel time between client homes.

### Consequences:

While many adult care workers find intrinsic satisfaction in their job, low pay and poor working conditions often prompt them to leave (Howes 2008). Turnover is high across all sectors of the adult care industry, related to problems of low wages, low morale, absenteeism, and burnout (Hewitt and Lakin 2001). Certified nursing assistant (CNA) turnover averages 71 percent a year in nursing homes nationwide, and it reaches even higher levels in many states (Decker et al. 2003). An estimated 40 percent to 60 percent of home health aides leave after less than 1 year on a job, and 80 percent to 90 percent leave within the first 2 years (IOM 2008). Staff turnover in assisted living ranges from 21 percent

to 135 percent, with an average of 42 percent (Maas and Buckwalter 2006). One recent study of three categories of female adult care workers found that hospital aides and nursing home aides had a higher propensity for remaining in their occupation than home health aides. Higher wages, being older, having children and being Hispanic were other significant predictors of remaining in the adult care profession (Smith and Baughman 2007a).

Other studies have found a large percentage of home health and personal care assistants intend to leave the job within a year or two. A PHI analysis of the Home Health Aides Survey found that 35 percent intended to leave within a year. Brannon et al. (2008) found 39 percent intended to leave within a year. Another study found that 47 percent intended to leave within 2 years, and that intent to leave was a very good predictor of whether people did leave. Within two years, 46 percent of the sample had in fact left. The main problems cited were low wages, too few hours and lack of travel reimbursement.

The disruption that comes from turnover is likely to lower the quality of care provided. When these personal relationships become temporary, workers have less incentive to invest in them. Further, frequent turnover requires existing care workers to work overtime, which makes them “susceptible to exhaustion, increased mistakes and decreasing quality of performance” (Hewitt and Lakin 2010). Turnover increases employer costs because of the need for continuous recruitment and training. The costs of adult care worker turnover on the national level have been estimated at a total of \$4.1 billion per year (Seavey 2004). State-level studies also yield high estimates (Leon et al. 2001).

Turnover and retention seem to be driven by different forces. Workers report that they remain in these jobs because of their sense of satisfaction from doing the work and their interactions and relationships with care recipients and their families; they tend to leave these jobs because of extrinsic conditions like poor management, lack of respect, and the sheer physical and emotional difficulty of the work (Mittal et al. 2009). Howes (2008) reported that “attachment to the consumer” was the most important factor that kept IHSS workers in the job, but that wages and benefits and more hours were

the most important reasons why they would leave the job. This “dual-driver model” suggests retention depends on respecting workers’ intrinsic and extrinsic motivations, providing better wages and working conditions but also creating a supportive work environment that facilitates autonomy, discretion and collaboration.

If home care, and especially consumer-direct home care, is going to be the ballast for the long term care system, getting a good high quality care system means states will have to make these jobs sufficiently attractive to recruit and retain enough workers.

States will need to design contractual relationships which capture the qualities of caring labor that families are intrinsically motivated to provide. The system must embody extrinsic motivators, such as living wages and health insurance, which are sufficient to generate an adequate supply of labor. It must protect the personal relationship between the caregiver and recipient that is such an important motivator of quality care. It must shelter that relationship from some of the market forces that push care-giver wages to the bottom of the wage distribution and crush intrinsic motivation. It must provide sufficient regulation to ensure that providers who are injured on the job are covered by workers’ compensation and that an employer makes the mandatory employer contributions on behalf of the worker to the social security fund. Finally, it should, within reason, help constrain long run growth in the costs of long term care. Several dimensions of the homecare arrangement matter – whether kin can be paid to provide care, whether the pay comes directly from the care recipient or from a third party and whether the labor market is regulated.

Public authorities thus represent a “significant development in state efforts to improve wages and benefits and working conditions. Since 2005, a new authority has been created in Massachusetts, joining other authorities in California, Oregon, Washington, and Michigan. These authorities typically allow for collective bargaining regarding wages and benefits for these direct-care workers. PHI estimated that in 2009 over 400,000 personal care workers across the United States were covered

through public authority arrangements that help them advocate for improved compensation, training, and other supports (PHI & DCWA 2009). As of January 2011, there were over 350,000 in California alone.

### California consumer-directed homecare program

California runs the largest consumer directed personal care assistance program in the world. Like Connecticut, It has one of the highest coverage rates for long term care services in the nation. Over 13.8 persons, per 1,000 in the California population got publicly financed long term care services in 2006, just below the 15.0 per thousand rate in Connecticut, but well above the national average of 10.78 (Howes 2010). But unlike Connecticut, California ranks among the top 5 states in terms of the ratio of non-institutional to institutional care. Under the California program, nearly 450,000 consumers received an average of 100 hours of care per month in their homes in 2010. Two thirds, 9.6 per thousand were enrolled in the IHSS program, while 4.2 per thousand received long term care in nursing homes. The per capita cost to state and federal tax payers was \$210, in contrast to Connecticut's per capita cost of \$392. Much of the per capita cost difference can be explained by Connecticut's greater reliance on nursing homes where 11.2 persons per thousand received Medicaid long term care. Only 4.8 Connecticut residents received Medicaid long term care services through home and community-based services (Howes 2010; CAPA 2011; Harrington et al. 2010).

IHSS creates a huge demand for workers. During the calendar year 2010, IHSS employed 375,000 care-givers (CAPA 2011). Since the California program was organized under a Public Authority model – similar to the Personal Care Attendant Quality Home Care Workforce Council being proposed in Connecticut - beginning in the 1990s, working conditions for this vast work force, and the quality of care for consumers, have improved. My findings suggest that California PCAs are better paid, far more likely to have private employer-based health insurance and far less likely to be receiving income support or be

enrolled in Medicaid than PCAs nation-wide. My research also shows that the turnover rate for California PCAs, at 25 percent, is half the annual turnover rate of PCAs nation-wide.

IHSS is a consumer-directed home care program. A social worker authorizes the number of hours of paid service, following an assessment of the individual's need. Program participants who live in households with other people, for example, are authorized fewer hours for the same level of impairment as a person who lives alone on the assumption that they do not need as much assistance with housekeeping and chores. The recipient chooses her/his own provider, who can be a friend or relative or someone they have found through the public authority registry, and, pending a criminal background check, the state hires the provider. While the number of authorized hours is determined by an algorithm that includes estimates of how much time is required to do each task, once hired, the consumer and provider work out the details of the work arrangement. More than half of IHSS consumers hire a relative and virtually all hire someone they already knew (Howes 2005).

Although the care recipient can choose their own provider, they are not the "employer," in the sense that they neither set the wage nor pay the provider. The Public Authority in each county serves as the employer of record for the purpose of setting, or negotiating the wage. Providers submit time sheets monthly and the state pays them directly. There are currently 56 public authorities in 58 counties in California. One of the principal functions of the Public Authority is to help consumers get greater access to high quality providers. The Public Authorities maintain registries of screened and qualified providers and provide training for consumers and providers (CAPA 2011; Delp and Quan 2002; Boris & Klein 2006)

IHSS was officially created in 1972 to consolidate organization and provision of a rapidly expanding state home care program. As the program grew during the 1980s two unions started organizing drives. In 1987, following an extensive grassroots organizing effort in Los Angeles, the Service Employees International Union (SEIU) collected signatures from 20,000 workers to file for an early

election. Over time, home care workers in the United States have been organized into unions, mainly in urban areas, and exclusively through the agencies that employ them. IHSS providers did not have an agency employer, and while they were hired by the consumer, the consumer was not their employer. They were technically classified as “independent contractors” who, under U.S. labor law, do not have the right to join unions and bargain collectively. The National Labor Relations Board (NLRB) ruled against the union’s request to hold an election.

Five years later, in 1992, the state passed legislation that brought in new federal Medicaid money and expanded program eligibility. It also enabled the establishment of public authorities which could serve as employers-of-record for the purposes of collective bargaining. So at a time of extraordinary expansion in the program, the legal impediment to organizing the workforce disappeared and between 1994 and 1999 seven counties established public authorities and all seven had union elections culminating with the election in Los Angeles that brought 74,000 new homecare workers into SEIU (Boris & Klein 2006; Delp and Quan 2002; Heinritz-Canterbury 2002; Walsh 2001). In 1999, the California state legislature passed a bill that would require all California counties to set up employer-of-record entities by 2003. The legislation also set a target wage rate of \$11.50 an hour, plus \$0.60 per hour to be contributed to a health insurance benefit, which all counties were supposed to reach by 2006. By January 2011, 56 out of 58 counties had public authorities and X percent of IHSS workers in California belonged to a union.

The IHSS wage rate, which is uniform within a county, but varies across counties, is determined or negotiated by each public authority (or other public entity) in each county. The cost of the IHSS program is shared between the federal government, the state and each county. Under Medicaid regulations that govern the federal contribution, the federal government pays 50 percent of every dollar spent on IHSS services. State IHSS regulations specify that the state pays 65 percent of the non-federal

share and the counties pay the remainder. All funds come from tax revenue at the federal, state and county level. The state contribution is paid out of the general fund. The county contributions come from tax funds that are ear-marked for IHSS and other social services. As of January 2011, one county was paying \$12.10 per hour plus health insurance to people who work as few as 35 hours per month. Ten more counties paid between \$11.50 and \$11.55, plus health benefits, and providers in 11 counties received no benefits and were paid the state minimum hourly wage of \$8.00. (CAPA 2011). In addition to paying higher wages and benefits, some county public authorities have set up respite services.

Under the public authority model in California, worker turnover rates have fallen and consumers have been able to keep workers longer and with more reliable, flexible and committed workers, unnecessary medical emergencies can be mitigated.

Analysis of results from a survey I conducted in 2004-05 of IHSS workers provides a description of who the workforce is and, when compared to national Current Population Survey data for personal care assistants, some evidence to support the hypothesis that IHSS workers are drawn from the same population as personal care aides nation-wide, but despite not working for agencies or institutions are doing as well or better than their counter parts in other states and with salubrious consequences for consumers (Table 1).

By July 2004, when the survey was fielded, all but a few California counties had set up public authorities and 39 had already conducted successful union elections. At least 13 counties were paying wages of \$9.50 and higher and, including those 13 counties, 26 counties had set up individual health insurance plans for their IHSS workers. In San Francisco, the wage had reached \$10.28 an hour and employees were eligible for health insurance if they worked 35 hours a month for 2 consecutive months. As an organizer in the Chinese community in San Francisco reported to me, IHSS jobs had become one of the most sought after jobs in the community (conversation with Leon Chow).<sup>iii</sup>

IHSS workers had higher average wages in 2010 although they are slightly less well educated than personal care aides in the U.S. as a whole. This is despite many still living in counties where the wage is only \$8, the state minimum wage. They are still poor. Six years earlier, they had reported average individual and household monthly incomes of \$1,300 and \$2,300 which placed them in the bottom 30 percent of the income distribution with other personal care assistants. Only 18 percent of all homecare workers reported having enough money coming into the household each month to pay the bills. Fifty-four percent of homecare workers reported owing money on their credit cards, with an average of \$6,400 for foreign- and \$5,900 for native-born workers. Six percent of native and three percent of foreign-born workers reported receiving income support from Transitional Assistance for Needy Families (TANF), though, notably these numbers were down from 8 and 10 percent immediately before they became IHSS workers. Six percent of all workers received food stamps and 15 percent of foreign-born and 12 percent of native born got public medical insurance through MediCal, the Medicaid program in California.

They worked far fewer hours in homecare than the national average and about 1/3 held other jobs, so they were twice as likely to hold a second job as personal care workers nationally. Even though they were working part time in one or both jobs, they had a far greater probability of having private insurance – 61 percent compared to 45 percent nationally – and were far less likely to be uninsured. Thirty-one percent of personal care aides, nationally, were uninsured, compared to 15 percent in California.

In the year the survey was conducted 29 percent of IHSS workers were unionized; today the number is much higher and far above the current 8 percent unionization rate of homecare workers nationally.

IHSS providers were working mainly for friends and family. Eighty-four percent of providers reported that their first client was someone they knew and 81 percent reported that both their first and current client were people they knew. Only 14 percent did not know their first client and only 11 percent did not know their first or current client before they started to provide their care.

They first learned that they could do IHSS work through networks – 60 percent learned from a family member or friend who either needed the care or knew about the service. About one-third learned about the service when a family member was admitted to a hospital or otherwise required care and a doctor or nurse or social worker told the care provider that the consumer was eligible for IHSS services.

IHSS workers occupy a place in the workforce that is similar to personal care aides nation-wide, routinely working in third tier jobs that pay about \$500 per week. The jobs they held prior to or concurrently while working for IHSS were jobs typical of foreign born workers with low levels of education. With the exception of some Chinese workers and many Russian workers, IHSS workers' education levels were typical of all PCAs. Fifty-four percent had a high school education or less; a higher percentage had education beyond the bachelor's degree, but that level of education was concentrated among Russian immigrants.

Fifty-four percent of IHSS workers held another job prior to working for IHSS and 37 percent of homecare workers were working at a second job at the time they completed the survey. For the most part these current and prior jobs were concentrated in other low-wage occupations that commonly are done by persons with less than a high school education. For both foreign- and native-born workers, the other jobs their second (and even third) jobs were concentrated in homecare, administration, clerking, factory work, childcare and office work. Foreign-born workers were somewhat more heavily concentrated in the least desirable jobs such as working as maids and in factories but most of the jobs

done by homecare workers, whether foreign- or native-born fall squarely in the category of low skill jobs paying low-wages and no benefits. They saw their future including more homecare, but otherwise doing similar jobs, concentrated in the range of low-wage jobs that are available to workers in these communities.

### Conclusion

My research has shown that by establishing public authorities, California has been able to create a far more stable and satisfied workforce than is true among PCAs nation-wide. The turnover rate in California is half that of PCAs nationally and PCAs are only half as likely to be uninsured and considerably less likely to be on public assistance. While research that directly links turnover to lower emergency medical incidents has yet to be done for this population of consumers, in all likelihood, that is one of the results of managing personal care through a public authority model.

Table 1. Demographic and Economic Characteristics of U.S. and California Personal Care Aides

|                                      | Personal Care Aides |                   |
|--------------------------------------|---------------------|-------------------|
|                                      | US - 2010           | California - 2005 |
| Percent of all personal care workers | 100.0               | 100               |
| Percent Female                       | 88.0                | 78.5              |
| Weighted N (1,000s)                  | 944                 | 114               |
| Unweighted N                         | 646                 | 2,203             |
| <b>Economic Characteristics</b>      |                     |                   |
| Median hourly wage <sup>1</sup>      | \$9.50              | \$11.00           |
| Average weekly hours of work         | 33.8                | 18.4              |
| More than one job                    | 14.1                | 37.1              |
| Union membership                     | 8.2                 | 29.1              |
| Full-time employment <sup>2</sup>    | 58.4                | 46.1              |
| Self-employed                        | 7.2                 | --                |
| Health Insurance                     |                     |                   |
| Public                               | 33.3                | 24.0              |
| Private                              | 45.0                | 61.0              |
| No Insurance                         | 31.2                | 15.0              |
| 200 percent FPL Public assistance    |                     |                   |
| <b>Demographic Characteristics</b>   |                     |                   |
| Average age                          | 43.8                | 47.9              |
| Education                            |                     |                   |
| High School or Less                  | 55.2                | 54.4              |
| Some College: No Degree              | 24.5                | 30.7              |
| Associate's Degree                   | 8.4                 |                   |
| Bachelor's Degree                    | 9.6                 | 9.9               |
| More than Bachelor's Degree          | 2.4                 | 5.0               |
| Race and ethnicity                   |                     |                   |
| White-non-Hispanic                   | 49.2                | 33.8              |
| Black, non-Hispanic                  | 23.2                | 19.0              |
| Asian, non-Hispanic                  | 6.3                 | 19.1              |
| Other, non-Hispanic                  | 3.2                 | 2.0               |
| Hispanic                             | 18.1                | 26.1              |
| Foreign-born                         | 22.7                | 58.3              |
| Marital status                       |                     |                   |
| Married                              | 35.3                | 52.3              |
| Previously married                   | 31.2                | 26.1              |
| Never married                        | 33.6                | 21.6              |
| Children under 18 years              | 37.9                | --                |
| Single mothers                       | 22.3                | --                |

Source: 2010 March CPS, analyzed by Smith and Schaefer (from Folbre et al. (forthcoming))  
 Howes survey of IHSS Workers in California, 2005  
 Percentages based on weighted data for all workers 19 years and older.

Hourly wage and hours reflect 2009 employment; all other characteristics refer to 2010  
\*Hourly wages are calculated using total annual earnings in 2009 divided by usual hours worked per week multiplied by the number of weeks worked in 2009.  
\*Includes those working 35 or more hours per week  
\*Includes those working 35 or more hours per week and 50 or more weeks annually

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