

# *The Long-Term Care Labor Force Crisis*

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## *Introduction*

**T**here is a growing consensus that America's long-term care (LTC) system faces a crisis in providing sufficient health care and social needs to an aging society (Bragg and Hansen 2011; Bryant and Stone 2008; Institute of Medicine 2008; Miller, Booth, and Mor 2008; Stone and Barbarotta 2011). A major concern is the impending disparity between the increasing demands of health care needs and the decreasing supply of the LTC workforce. The first of the baby boom generation began turning sixty-five in January 2011 (Stone and Barbarotta 2011), and since then the amount of individuals requiring LTC has been increasing considerably. The government estimates that the number of persons utilizing paid LTC services will raise from 15 million in 2000 to 27 million in 2050 (Friedland 2004).

At the same time, the overall labor force relative to the population size will likely be smaller than it is today, and there will be fewer adult children to provide informal care to their aging parents due to declining fertility rates (Friedland 2004; Lakdawalla and Philipson 2002). In order for the LTC workforce to keep pace with the substantial increase in the aging

population, it would need to grow, at a minimum, by more than 2 percent each year; however, it is currently only expected to increase by 0.3 percent per year (Friedland 2004). Future policies must address this shortage by ensuring the availability of a large and competent paid workforce. The problem is that the current workforce is unstable, which make it difficult to recruit and retain workers. This, in turn, has negative effects on quality care.

At present, there are multiple factors that negatively affect the LTC workforce and quality of care, which will continue in the future if the issues are not addressed. These factors include: a rapidly aging population, a heterogeneous group with different needs, an inadequate workforce, an absence of incentives, and the different demographics of the frontline workers and their care recipients. This issue brief provides a description of each issue and explains how it is problematic for the LTC labor force system and the recipients.

## *Population Aging*

Individuals eighty-five and older are most likely to utilize LTC services, and their numbers are projected to increase five-fold (Institute of

Medicine 2008; Stone and Barbarotta 2011). It is estimated that between 14.8 and 22.6 million Americans will need LTC services by 2020 (Stone and Wiener 2001).

The need for more general personal assistance services is predicted to double from 13 million in 2000 to 27 million in 2050 (Kaye, Chapman, Newcomer, and Harrington 2006). Middle-aged women, who tend to provide the majority of formal and informal care today, are aging and will begin to require assistance themselves, thus decreasing the number of such women available to provide low-skilled direct care services (Feldman 1997; Stone 2004). In addition, baby boomers may be more prone to pay for services rather than rely exclusively on informal care from family members due to increased levels of income they have gained throughout their working years (Manchester 1997; Stone and Wiener 2001). These trends will drastically raise the demands for formal LTC services over the next few decades.

The LTC dilemma extends beyond the deficient supply of the future labor force (Stone and Wiener 2001; Stone 2004). When dealing with providing personal care for the aging adult, simply filling positions with anyone who applies is not sufficient, for this existing practice has led to an inadequate workforce and poor quality of care.

### *Heterogeneous Group*

The members of the Baby Boom generation span nearly 20 years and represent a diverse

group of people whose experiences, values, and life stages vary not only from preceding generations, but also from each other (Hughes and O’Rand 2004). On the positive side, by choosing to work longer and maintain good health from staying active, they will likely redefine and extend the length of midlife into what we consider now as old age. On the negative side, the boomers have the highest amount of inequality and poverty levels during middle-age than any other recent generation (one in ten of the late boomers live in poverty), which means they will have less saved for retirement than previous generations. In addition, nontraditional families, such as single parents, those who never married, or had no children, will likely have less social support from family during times of need.

Understanding this diversity of the baby boom generation can assist health care professionals in determining the needs of this population, and better serve them in the future as they continue to age.

### *Inadequate Workforce*

Even if the shortage of LTC workers were to be resolved, it would be difficult to find quality workers to provide sufficient care with the current system. The specific needs of the aging population require employees of all areas – from physicians to nurse assistants – to be competent in the field of geriatrics, and valued by their employers. However, the LTC labor force today is made up of workers who have minimal education and training in this area, and

are undervalued. Some positions, such as certified nurse assistants (CNAs), are paid minimal wages with little or no benefits and few opportunities for career advancement.

The current curricula for students in the healthcare field – medical, nursing, social work, psychiatry, psychology, physical therapist, and pharmacist – does not provide much exposure to geriatrics or gerontology, which has led to insufficient levels of qualified geriatric healthcare professionals (Stone and Barbarotta 2011). The mean number of geriatricians per 10,000 aging adults (75 and older) is 3.7 (Bragg and Hansen 2011). Projections estimate that 20,000 geriatricians are currently needed to care for more than 14 million older adults, and 30,000 geriatricians will be needed by 2030 to care for approximately 21 million older adults (American Geriatrics Society 2017). Given that there were 7,293 certified geriatricians in 2016, it is expected that around 1,600 geriatricians must be trained per year over the next 14 years to meet the targeted need for 2030 (American Geriatrics Society 2017).

Paraprofessional careers in LTC, such as CNAs and home health aides, are undervalued and underpaid in our society. In 2010, the median hourly wage for home health aides was \$10.46, and for nursing aides the median hourly wage was \$12.09 (U.S. Bureau of Labor Statistics, 2010). In 2016, the median hourly wage for home health aides was \$10.66, and

for nursing aides the median hourly wage was \$12.78 (U.S. Bureau of Labor Statistics, 2018). That is less than a dollar increase in six years.

In addition to inadequate pay and little benefits, the paraprofessional occupations are viewed as dead-end jobs due to the paucity of career advancement opportunities (Weiner, Squillace, Anderson, and Khatutsky 2009). Low levels of education and insufficient training make it difficult for these workers to improve their skills and confidence, and thus, move up the ladder. Furthermore, additional experience does not necessarily lead to higher wages. For instance, CNAs with ten years of experience only earn on average \$2 more per hour than a CNA with less than one year of experience (Katz and Frank 2011; Squillace et al., 2009). Overall, low wages, little benefits, and few opportunities for career advancement, not only reflects the marginality of their work within the health care system and our society in general, but also leads to low job satisfaction and high turnover rates among the paraprofessionals in the LTC labor force. High levels of turnover have negative effects on providers, workers, and consumers.

### *Absence of Provider and Employee Incentives*

With the current system, there is a deficiency of incentives for LTC providers and their employees. Providers of LTC services do not receive incentives that encourage them to recruit and retain a qualified workforce.

Medicaid is a major source of funding for LTC services, and government reimbursements affect the supply and demand of workers (Bryant and Stone 2008). Many providers argue that the Medicaid reimbursement rates “are not adequate to support a quality workforce and the delivery of quality care” (Bryant and Stone 2008: p. 72). Low reimbursement rates limit the ability of providers to pay competitive wages, offer benefits, and offer in-service training to their employees (Bryant and Stone 2008). This often leads to the hiring of under-qualified workers.

There is also a lack of incentives that motivate existing and future LTC employees to obtain specialized training in geriatrics and to stay in the field. For direct care workers, low wages and few benefits do not encourage job tenure. When examining which factors increase job tenure for CNAs in nursing homes, Wiener and colleagues (2009) found that out of all the different variables included in the study, extrinsic rewards - paid days off, a pension plan, paycheck of \$1 more per hour, and a mentor - appeared to be the most consistent determinant.

Overall, the formal LTC system lacks incentives that have the potential to inspire people to further their education in geriatrics and for retaining workers, which are important factors for producing a quality workforce. Providing incentives for educators, students, and direct care workers can help to create

better jobs and ensure better care. Friedland (2004) advises, “The more valuable long-term care workers are to long-term care facilities and organizations, the more willing workers will be to enter the field and the more likely they will be to stay” (p. 10).

### *Demographics of Frontline Workers and their Care Recipients*

In order to successfully implement strategies for recruiting and retaining direct care workers, it is first important to identify and understand the characteristics of the current workforce (Montgomery, Holley, Deichert, and Kosloski 2005). Direct care workers include individuals from various backgrounds and different ages.

The Paraprofessional Healthcare Institute (PHI) examines the national and regional status of the direct care workforce. In their most recent study (2017), they found that 88 percent of the direct care workers are female. The median age for all direct care workers is 45 years old. Almost half (42%) of the direct care workers are White, non-Hispanic, 28 percent are Black or African American, 21 percent are Hispanic/Latino, and 9 percent are other races or ethnicities (PHI 2017). Thirteen percent of home care workers are foreign born and 37 percent speak a language other than English (PHI 2017). It has been suggested that, “The wide variation in ethnicity and cultures represented among staff in LTC settings has heightened the potential for tension, miscommunication, and conflict between

caregivers and care recipients, between peers, and between supervisors and direct care workers” (Stone 2004: p. 14).

These individuals are typically single moms, and have low levels of educational attainment, with 35 percent having a high school diploma (PHI 2017). Two-thirds work part time or for part of the year (PHI 2017). The median income in the U.S. is \$56,516 (U.S. Census 2015) compared to \$13,800 for all direct care workers (PHI 2017). Twenty-three percent live in households below the federal poverty line, and over half use public benefits such as Medicaid or food stamps.

By 2050, the racial and ethnic composition of the older adult population will be different than today. The White, non-Hispanic population is expected to decrease from 80 percent to 59 percent (Leutz 2011). The proportion of Hispanics is projected to increase from 7 percent to 20 percent, the Asians from 3 to 9 percent, and blacks from 9 to 12 percent (Leutz 2011). Since there are differences in how racial/ethnic groups utilize LTC services, increases in diversity among care recipients will pose challenges for training future healthcare providers (Alecxih 2001; Xakellis, Brangman, Hinton, Jones, Masterman, Pan, Rivero, Wallhagen, and Yeo 2004).

### *Summary*

There are legitimate concerns regarding how to provide quality care to a rapidly aging society with a declining LTC workforce. The factors

presented in this issue brief illustrate the current and future predicament of providing sufficient health care and social needs to our aging adults. Although certain initiatives have been put into place, the challenge for the 21st century workforce continues. Given the scope of the current and future deficits of preparedness, there need to be, not only a continuation of research and demonstration projects to test the effectiveness of new programs and to find any other gaps in the system, but also more widespread implementation of the successful programs. Finally, educators and providers must be able to attract, train, and maintain a workforce that is committed to providing quality care to the aging adult population. In order for this to happen there needs to be a shift to more positive attitudes toward aging adults and their caregivers from both the private and public sectors. This begins with an educated workforce with an interdisciplinary understanding of the aging process.

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