Essential and Exiting:

COVID-19's Impact on Low-Wage Healthcare Workers

CENTER ON WOMEN, GENDER AND PUBLIC POLICY
UNIVERSITY OF MINNESOTA

The COVID-19 pandemic has laid bare the crushing working conditions, dismal wages, and physical risks of direct care work in the healthcare sector.

Direct care workers include nursing assistants, home health aides, and personal care aides – low-paid workers that provide hands-on care for older and disabled people. Direct care workers have been on the frontlines of caring for COVID-19 patients and patients at high risk of COVID mortality, often without adequate personal protective equipment. Many have opted to leave the profession.

Key Findings

6.5% of direct healthcare workers **left the labor market** in 2021, an elevated rate compared to pre-pandemic

40% of direct care workers **transitioned to another occupation** between January 2019 and December 2021

Qualitative interviews with Minnesota workers revealed widespread reports of **workforce shortages** and **heavy workloads** for remaining staff

Policy Recommendations

Redistribute Medicaid and Medicare spending

Support unionization

Training and credentialing may not be the answer

"I do think that healthcare can really evolve [in] how they build their organizations and value their employees." – **CNA, Public Health**

The crisis of low-wage healthcare workers is a crisis for all those that require health care.

In 2022, Minnesota nursing homes reported the largest staffing shortages in the country, and the state's Department of Human Services has called attention to the direct care worker shortage in the state.[1]

Through analysis of national data drawn from the Current Population Survey and interviews with 26 Minnesota women who were employed in direct healthcare work at some point during the COVID-19 pandemic, this report examines the impact of COVID-19 on these workers and the reasons for staff shortages in this labor market. During these interviews, workers described challenges that emerged or were intensified during the pandemic.

Women make up 85% of the direct care workforce in Minnesota; 36% of these workers are people of color.

Women, especially women of color, are overrepresented among low-paid direct care health occupations nationally and in Minnesota. In Minnesota, the direct care workforce is 85% female; 63% identify as white, 22% as Black, 5% as Latino(a), 5% as Asian, and 4% as another race or ethnicity. (By comparison, the state of Minnesota is 79% white and 21% Native American and people of color.) Nationally, Black women are overrepresented in direct care occupations, reflecting a legacy of slavery and domestic servanthood that persists in our labor market today.[2]

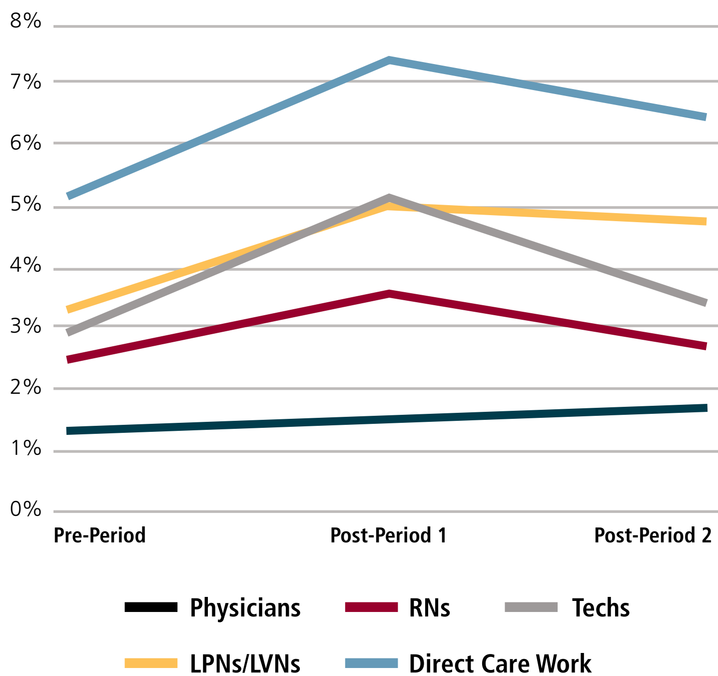
Despite the crucial nature of this work, the pay is poor. Nursing assistants in Minnesota earned $17.34 per hour on average in 2020, while home health and personal care assistants earned $14.72 per hour. The overall average wage for direct care workers was $14.72 per hour in 2020. Over 40% of direct care workers in Minnesota earn wages that are below 200% of the federal poverty line, and around 40% have insurance through Medicaid, Medicare, or another public source.[3]

Direct care work has long had a high turnover problem– workers coming and going due to poor working conditions. The pandemic has resulted in fewer coming, and more going.

Even prior to the pandemic, high rates of turnover have been a challenge in the direct care workforce. Low wages, limited benefits, and financial uncertainty make direct care work difficult to align with other personal, financial, or family duties.[4] For example, a nursing assistant may struggle to maintain employment because they do not have reliable transportation or child care, or may leave for higher wages offered in retail.

The pandemic introduced additional reasons workers might exit direct care work, including the risk of infection, closure of schools and child care centers exacerbating child care needs, or rising wages in other sectors. High turnover led to staffing shortages, which meant that remaining direct care workers dealt with even heavier workloads.

National exit rates by health care occupation, 2019-2020



Data source: IPUMS-CPS.
US National Data. Pre-Period = Jan 2019-Mar2020; Post-Period 1 = Apr 2020-Dec 2020; Post Period 2 = All of 2021
Frogner BK, Dill JS. "Tracking Turnover Among Health Care Workers During the COVID-19 Pandemic: A Cross-sectional Study." *JAMA Health Forum.* 2022;3(4):e220371. doi:10.1001/jamahealthforum.2022.0371

> *"It was just very, very draining, it's still short-staffed… a lot of people who just don't want to come back into the field at all. Because we were already short-staffed and then COVID hit and then there were people who were like 'nope I'm not going to deal with that, I don't want to be in that'… there's just people not coming back and there's not new people that want to join."*
> **– CNA, Long Term Care**

Among health care workers, direct care workers have the highest rate of exit both before and after the start of the pandemic. However, post-pandemic onset, new workers have not entered the field at the same rate as workers in other health care occupations. Prior to the pandemic, in 2019, around 5% of direct care workers left the labor market. During the first year of the pandemic, this rate rose to above 7%, and in 2021, the rate was 6.5%, indicating that direct care workers were still leaving the labor market at an elevated rate compared to the pre-pandemic period.

What occupations are direct healthcare workers moving into? Around 40% of direct care workers during the pre-pandemic period and post-pandemic periods in our study transitioned to a new non-direct care occupation. Most transitioned into other health care jobs, followed by office and administrative jobs. Retail, management, and food service are the other primary competing occupations. The types of jobs direct care workers moved into following the onset of the pandemic were similar to the jobs these workers left for in the pre-pandemic period.

Direct care workers may have chosen to transition to other occupations during and after the pandemic because of

heavy workloads and deteriorating job quality. During our interviews, some workers described how challenges in workload and staffing meant they no longer had time to engage in meaningful aspects of their work, such as building relationships with patients.

> *"I'd say the most challenging thing is probably being able to get all of your tasks done throughout the shift. And then, on top of that, being able to actually create a relationship with the patient throughout those tasks, instead of just 'I'm here to get my work done and then leave'. I feel like it has gotten more difficult throughout the pandemic just because there's less staffing so then you're picking up more tasks that you wouldn't have had to do otherwise, or at least you have to do more tasks for more people."*
>
> **– CNA, Long Term Care, Nurse Technician**

To resolve the direct healthcare worker exit crisis, we must raise wages and improve job quality.

Low wages and few opportunities for advancement make it difficult for workers to stay in the labor force and make it more likely that they will transition to other occupations where such opportunities exist.

> *"I still feel like the industry as a whole is pretty undervalued, considering the nature of the work. And with the pandemic, I think that it puts a lot more strain on things. So, I still think that the compensation and the kind of benefits that are available for that kind of work right now are still not what they should be."*
>
> **– Medical student and direct care worker**

Policy Recommendations

REDISTRIBUTE MEDICAID AND MEDICARE SPENDING

The Centers for Medicare and Medicaid (CMS) must develop a plan for how to redistribute Medicare and Medicaid funds to promote higher wages for direct care workers. Medicare and Medicaid reimbursement policies and practices often promote dramatic wage inequality within and across healthcare occupations, with the highest rates and rewards concentrated around services that tend to be male-dominated (such as surgery and procedures involving technology). Services that require the most hands-on care and that are female-dominated, such as direct care work, are reimbursed with the lowest rates. Federal Medicaid and Medicare rules constrain how much states can reimburse for direct care services.

The Minnesota legislature took steps in 2021 to provide inflationary adjustments in some sectors of direct care.[5] The state should explore where and how it can make more systematic changes. Altering policies to ensure compensation matches the skills of, and demand for, direct care workers would result in greater gender and racial-ethnic wage equity within the health care workforce.

SUPPORT UNIONIZATION

Union representation results in higher wages among direct care workers. Although gains vary, we find that unionized direct care workers earn wages about 8% higher than non-represented direct care workers. Unionization also has been shown to improve benefits, strengthen pro-worker public policies, and the use of earned benefits by employees.[6]

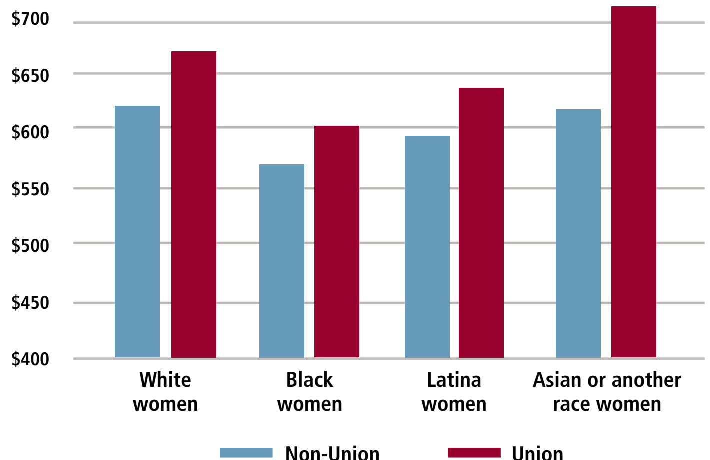
At the federal level, the Protecting the Right to Organize (PRO) Act of 2021 (H.R. 842) offers one way to promote unionization. Critical for workers in direct care jobs who are often considered self-employed or contract workers and therefore exempt from many labor laws, the PRO Act would allow them the right to unionize.[7]

In Minnesota, reimbursement and compensation rates for direct care workers are regulated through statute. Policymakers should collaborate with worker and provider organizations to build support for legislation to increase compensation rates, as recommended by the Direct Care Workforce Stakeholder Group's 2018 report.[8]

TRAINING AND CREDENTIALING MAY NOT BE THE ANSWER

While often touted, further credential and training requirements are not a solution to low wages and lack of upward mobility for direct care workers.[9] Certification requirements put substantial responsibility on individuals, who have differential resources and time to invest in training and credentials.[10] Recent research indicates that direct care workers of color are disadvantaged in earning credentials as compared to white individuals, and female and direct care workers of color do not receive the same rewards for certification compared to male direct care workers, who experience the highest increase in earnings when they have a certification.[11]

Weekly earnings among direct care workers, by unionization and race-ethnicity



Dill, Janette and Jill Tanem. 2022. "Race-ethnicity, gender, and unionization in direct care occupations." *American Journal of Public Health.*

"I really don't feel like nursing staff –whether it's a CNA or a trained medication aid or a nurse– I don't think that they're being compensated for the work that they do. It is a very mentally, emotionally, and physically difficult job. It's [a] very, very hard job, so if you're going to get hired as a CNA at $15 an hour and you take on that kind of responsibility and that toll of taking care of people, whereas you could go, like, for example, [to] McDonald's or Walmart. …I'm not demeaning those jobs in any sense, but it's the responsibility of taking care of people every single day. I feel there should be a higher compensation for that." **– CNA, LPN**

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The Center on Women, Gender, and Public Policy at the University of Minnesota's Humphrey School of Public Affairs illuminates gender-based disparities and their intersections with other inequalities through research, teaching, and public engagement. Formed in 1984, the Center was the nation's first comprehensive teaching, research, and outreach center devoted to women and public policy. We build on this legacy today as we work to provide students, researchers, policymakers, and the broader public with tools to better understand how public policy impacts gender equality in our local communities, throughout the United States, and around the world.

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