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How Immigrants Can Fill Home Health Aide Shortages in America's Rural Communities

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EXECUTIVE SUMMARY

The retirement and aging of the country's 76.4 million baby boomers will undoubtedly change our healthcare system and society in countless ways. Studies have found that the average elderly individual spends over three times more on healthcare each year than the average American of working age.[1] Today's baby boomers will likely widen that gap further—as many are expected to live longer, while also battling chronic, longstanding conditions. By 2030, for instance, experts predict more than one in four baby boomers will have diabetes and more than half will have arthritis.[2] The healthcare industry is already preparing for this sea change in American healthcare use—creating more jobs in fields such as pharmaceutical manufacturing and nursing facilities in preparation for a period of soaring demand.

But perhaps no other profession will be as profoundly impacted by the graying of America's population as home health aides, workers who help both seniors and younger, disabled individuals cope with their immediate medical needs and the basic tasks of daily living at home. Today, the country has 875,000 home health aides, but the profession is expected to grow rapidly, in no small part because hiring an aide can be a cheaper alternative to entering a nursing home or assisted living facility full-time. Between 2012 and 2022, the U.S. Bureau of Labor Statistics projects that home health aides will be the third-fastest growing occupation in the United States.[3] PHI, a group that studies the industry, says that by 2020 America's direct care workforce—a group made up of nursing aides, home health aides, and the personal care aides that help mostly with day-to-day nonmedical tasks—will be 5 million people strong. That will make direct care workers the largest occupational group in the United States, just ahead of retail salespeople.[4]

As the demand surges for these types of direct care workers, however, many policymakers worry that the labor force is not prepared to meet the growing need, particularly in more isolated or rural areas.[5] While the number of home health aide jobs will grow by 48 percent between 2012 and 2022, the population of people who typically fill such jobs—working age women with less than a bachelor's degree—is projected to grow by just 2.1 percent. The industry also consistently has trouble attracting U.S. workers, given long hours, as well as the physical and mental challenges associated with the job. Furthermore, efforts to raise industry wages in recent years have faltered, creating another obstacle to attracting workers to the field. Already, some parts of the country are reporting severe home health aide shortages. One 2015 national survey of home health care administrators, for instance, found that 62.8 percent identified "caregiver shortages" as one of the top three biggest threats to growing their businesses this year.[6] Patients living in a variety of less urban areas, ranging from Western Massachusetts to rural Arkansas, report reaching out to local home health care agencies only to be told that full-time caretakers simply aren't available given the limited supply.[7] [8]

In this paper, part of a series on the healthcare workforce, we examine the current population of home health aides, comparing the differences in supply that exist between metropolitan areas and the more rural communities outside of them. Our work finds that despite having potentially greater medical needs, non-metropolitan areas are already falling behind in the race to provide enough home health aides for consumers. As demand escalates in the coming years, such communities may face even greater challenges providing residents with appropriate levels of care. This, combined with the smaller number of physicians in rural communities per capita, may make the 11.1 million baby boomers and elderly individuals living in such communities particularly vulnerable to healthcare challenges as they age.

In the coming years, many steps must be taken to address the shortage of home health aides—particularly given the high injury rates and turnover in the profession.[9] It is clear that, at least in the near term, immigrants may be particularly well positioned to fill some of the workforce gaps. Immigrant workers in general tend to be younger than the native-born population—a valuable attribute given the physically demanding nature of the work. The foreign-born population is also far more likely than the native born one to have either a graduate degree or less than a high school education.[10] For the large share of less-educated immigrants then, home health aide work can be a stable position, well matched to their underlying skill set. There is also already enthusiasm for the work: Almost one out of every four home health aides in the country currently is foreign-born.[11]

KEY FINDINGS

» In an era when all parts of the country are in need of more health aides, counties outside of metropolitan areas are already behind.

On a per capita basis, there are currently almost 20 percent more home health aides working in metropolitan areas than there are in more rural communities. In 2013, metropolitan areas had 264 home health aides for every 100,000 people. Communities outside of metropolitan areas had only 224.

» Demographic trends mean that non-metro areas could have a particularly strong need for home health aides in the future.

Currently home health aides care predominately for elderly individuals or patients with disabilities. Both groups are more commonly found outside of metro areas. Currently, the average resident in a non-metro community 40 years old—or 2.5 years older than their metropolitan counterpart—an age gap that is quickly widening. Working-age Americans living in non-metro areas are also 51 percent more likely to be disabled than those living in metropolitan communities.

» In some states, the number of home health aides available outside of metropolitan areas is already incredibly low.

Nationwide, there are currently 258 home health aides for every 100,000 people. In the non-metro portions of Alabama, however, there are only 35 health aides for every 100,000 residents. In five other states, including Nebraska, Arizona, and Washington State, the equivalent figure is lower than 75.

» Immigrants could play an important role answering future gaps in our home health aide workforce.

Between 2012 and 2022, the number of home health aide jobs in America is projected to grow by 48 percent. At the same time, however, the group of native-born workers who typically gravitate towards such positions is projected to shrink, falling by almost 700,000 people, or 1.5 percent. By injecting young individuals with the appropriate skills into the workforce, immigrants could help mitigate some of the projected home health aide shortage. Already, 19 percent of foreign-born workers in the healthcare sector are in home health aide jobs, compared to just 10 percent of native-born health workers.

Despite the real need for home health aides in the country currently—and the role immigrants could play helping to fill such positions—little has been done in recent years to make it easier for immigrants to come to the United States and work in such roles. Currently, the United States has dedicated visas for less-skilled individuals with jobs in the agriculture industry or for immigrants engaged in temporary, seasonal work in places such as hotels and amusement parks. The country, however, lacks any sort of temporary visa that would allow employers to bring in other types of less-skilled workers, like home health aides, when no Americans are interested or available to fill such roles.[12] [13] The lack of geographic focus of our immigration system also continues to be a challenge for our healthcare industry, which suffers from a clustering of workers in urban centers. While countries like Canada and Australia allow individual provinces, cities, or regions to bring in the specific immigrant workers they need,[14] the United States lacks any such visa that would allow rural, medically-underserved areas to bring in desperately needed healthcare workers.

The unresolved debates in Washington surrounding immigration can also translate into day-to-day stress for the hundreds of thousands of American families that depend on home health aides for care. It is estimated that more than one in five immigrant workers in the broader direct-care industry are currently undocumented. Such workers are vulnerable to deportation and legal uncertainty as part of daily life. Helping undocumented workers achieve legal status would provide more stability to those families, particularly ones based in rural areas that may not have access to replacements.

The lack of geographic focus of our immigration system also continues to be a challenge for our healthcare industry.

SECTION I:
THE SUPPLY OF HOME HEALTH AIDES

The uneven distribution of healthcare workers in the country is a major issue that has long worried policymakers and experts. Rural counties have far fewer doctors per 100,000 people than larger urban centers.[16] Many rural communities also face particular challenges providing their populations with adequate numbers of dentists and mental health professionals.[17] [18] In this brief, we explore how this dynamic plays out in an industry of growing importance: the home health care workers who will provide in-home care to America's 76.4 million retiring baby boomers. With more than 70 percent of baby boomers saying they hope to live out their golden years at home,[19] the number of jobs in the industry are projected to grow by 48 percent between 2012 and 2022.

To examine the supply of workers in the field, we rely on 2014 data from the U.S. Bureau of Labor Statistics' Occupational Employment Survey. The data allow us to see the number of home health aides working per 100,000 people in metropolitan areas (cities and their surrounding suburbs) versus the more rural communities that fall outside them. To determine the number of people living in these areas, as well as basic information on their age and healthcare needs, we rely on the American Community Survey's 2013 data sample and U.S. Census Population estimates for 2014.

Our work shows that, much like other healthcare occupations, the supply of home health aides is more robust in urban areas. There are currently 17.9 percent more home health aides working per capita in metropolitan areas than there are in non-metro communities in the United States.[20] This is particularly concerning given that shortages are already known to exist in the industry nationwide. One 2015 national survey of home health care administrators, for instance, found that 62.8 percent identified "caregiver shortages" as one of the top three threats to growing their businesses this year.[21] Our work shows non-metropolitan areas are likely being hit disproportionately hard by the current home health aide shortage. The finding is also troubling given that non-metro areas have demographic characteristics that often translate into greater medical needs—a factor we discuss in more detail in the following section.

FIGURE 1:
Home health aides per 100,000 people in Metropolitan Areas

264

Home health aides per 100,000 people in non-metro areas

224

Source:
U.S. Bureau of Labor Statistics, Occupational Employment Survey, 2014

TABLE 1:
Number of Working Home Health Aides Per 100,000 People in Non-Metropolitan Portions of Each State, 2014

STATE	# OF HOME HEALTH AIDES PER 100,000 RESIDENTS	RANK, LEAST TO MOST
WASHINGTON	27.86	1
ALABAMA	35.14	2
MONTANA	60.95	3
ARIZONA	69.29	4
CONNECTICUT	72.09	5
VERMONT	75.45	6
NEBRASKA	83.66	7
OREGON	91.35	8
FLORIDA	91.60	9
WYOMING	91.84	10
MISSOURI	92.72	11
GEORGIA	94.76	12
UTAH	98.69	13
MASSACHUSETTS	98.89	14
MISSISSIPPI	102.07	15
WISCONSIN	102.61	16
NEW HAMPSHIRE	106.20	17
TENNESSEE	108.76	18
KENTUCKY	109.63	19
ILLINOIS	118.27	20
SOUTH DAKOTA	129.47	21
COLORADO	151.28	22
NORTH DAKOTA	152.81	23
VIRGINIA	156.51	24
CALIFORNIA	165.57	25
IDAHO	168.80	26
HAWAII	175.39	27
TEXAS	176.87	28
SOUTH CAROLINA	182.01	29
OKLAHOMA	202.56	30
NEW MEXICO	211.08	31
DELAWARE	217.57	32
MARYLAND	217.72	33
MAINE	221.44	34
INDIANA	223.00	35
IOWA	232.86	36
LOUISIANA	233.45	37
WEST VIRGINIA	261.74	38
ARKANSAS	287.03	39
KANSAS	288.36	40
MICHIGAN	289.33	41
ALASKA	308.94	42
PENNSYLVANIA	343.58	43
NEW YORK	345.90	44
OHIO	446.72	45
MINNESOTA	573.05	46
NORTH CAROLINA	614.79	47

Although the breakdown on a national level is troubling, when the data is viewed on a state-by-state level, the challenges facing some rural areas become more readily apparent. In the United States overall, there are currently 258 home health aides working for every 100,000 people. In the non-metro portions of some states, however, figures far well below that. The rural portions of Washington State, for instance, have just 28 home health aides per 100,000 people—roughly one ninth the number available per capita nationally. Alabama has only 35 home health aides per 100,000 people, and 12 other states, including Georgia, Utah, and Missouri, have fewer than 100. The figures for all states are shown in Table 1.

Source: *Bureau of Labor Statistics, Occupational Employment Statistics, 2014*

Note: *Because of reporting restrictions, estimates are not available for Washington, DC, Rhode Island, Nevada, and New Jersey.*

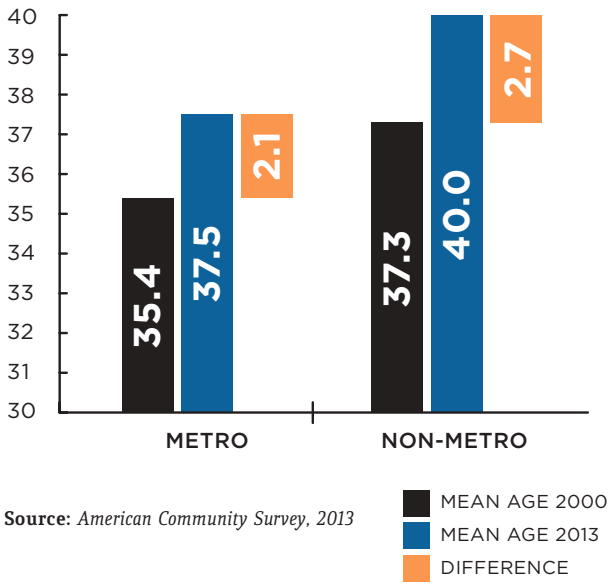
SECTION II: NON-METROPOLITAN AREAS HAVE GREATER HEALTH CARE NEEDS

The smaller supply of home health aides per capita in more rural communities is a cause for concern for many healthcare advocates and families in need of care. The gap between metro and non-metro areas, however, gains new resonance when we examine the increased healthcare needs that appear to exist in the more rural communities we examine here. Home health aides, as discussed earlier, generally care for elderly individuals as well as younger patients suffering from either chronic illness or disabilities.[22] In this section, we use data from the American Community Survey's 2013 sample, as well as the Social Security Administration, to estimate how the age of residents differs in metropolitan versus non-metropolitan areas. We also consider how rates of disability differ among younger populations in each community—a key indicator of potential home health aide need.

Our figures show that the average resident of a non-metro area is older than the average individual living in a metropolitan region—and also more likely to be elderly. In 2013, the average age of residents living in metropolitan communities was 37.5, while it was 40 in non-metro communities. While that 2.5-year age gap might appear small on the surface, in recent years, it has been widening—a trend that is expected to continue. Between 2000 and 2013, the average age of residents living in metropolitan areas went up by 2.1 years. In non-metro communities, the equivalent figure was 2.7.

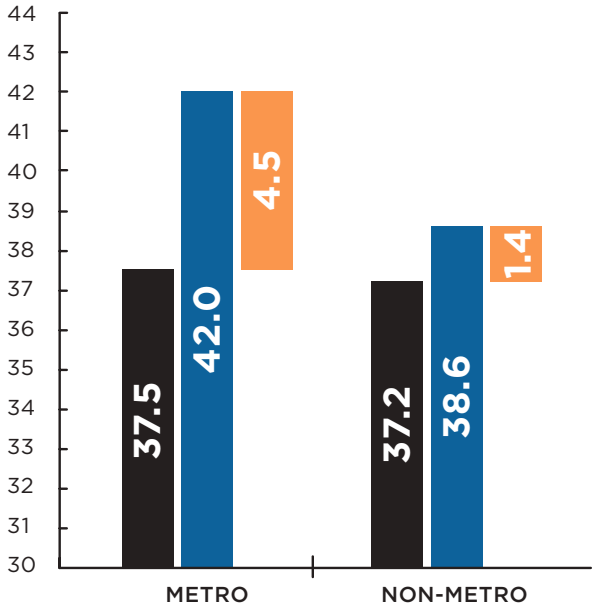
These figures make sense given recent aging trends in urban and rural America. In the last decade, many young people have left rural communities to move to urban areas in search of jobs, leaving a rapidly aging population behind. A forthcoming brief by the Partnership for a New American Economy explores this point in detail, looking at two types of smaller geographies that exist within metropolitan and non-metro areas: the largest, urban counties that form the core of many metropolitan areas, and small, rural communities, or counties with no town of more than 2,500 residents.[23] The study finds that while the average age of residents in large, metropolitan counties went up by just 1.4 years between 2000 and 2010, in small, rural counties it increased by 4.5 years.[24] [See Figure 3.]

FIGURE 2:
Aging Trends in Metropolitan vs Non-Metropolitan Areas, 2000-2013



Source: *American Community Survey, 2013*

FIGURE 3:
Aging Trends in Small, Rural vs Large, Urban Counties, 2000-2010



Source: *Area Health Resource Files, 2012*

Another indication that non-metro areas may have more concentrated demand for home health aide services can be found by looking at the share of the population in such communities that is already of advanced age. In 2013, almost one in six people living in non-metro communities, or 16.4 percent, were already older than age 65. In metropolitan areas, just 12.4 percent of residents fell into that category. When the elderly population is looked at together with baby boomers—a group that could soon have need for aides—the numbers become even more striking. In 2013, 11.1 million people living in non-metro areas were either elderly individuals or baby boomers, a figure equal to 43.3 percent of the population. In metropolitan areas, the equivalent figure was just 36.1 percent. [See Table 2.]

TABLE 2:
Population Falling into Different Age Categories in Metropolitan vs Non-Metropolitan Areas, 2013

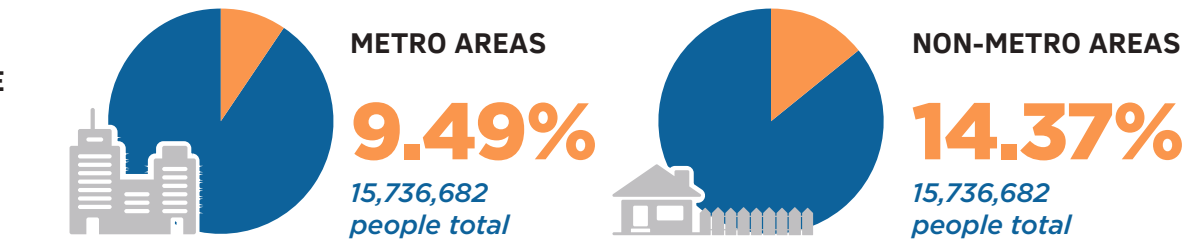
	WORKING AGE (18-64)	BABY BOOMERS (49-67) IN	ELDERLY (66+)	NUMBER ELDERLY + BOOMER	TOTAL POP.	% ELDERLY	% BABY BOOMER	% EITHER
METRO	156.1	57.9	30.4	88.3	244.6	12.4%	23.7%	36.1%
NON-METRO	15.8	6.9	4.2	11.1	25.7	16.4%	26.9%	43.3%

(ALL FIGURES IN MILLIONS)

Source: *American Community Survey, 2013*
Note: *The ACS includes some communities that do not fall into either the metropolitan or non-metro categories. Those communities were omitted from these results.*

Communities outside of metropolitan areas may also have greater demand for home health aides due to their higher underlying rates of disability. In 2013, 9.5 percent of working-age adults in metropolitan areas were disabled, compared to 14.4 percent of working age adults in non-metropolitan areas. This included individuals who suffered from a range of different types of conditions that would potentially necessitate the sort of assistance with daily living tasks and medication that home health aides provide—including those with independent living, self-care, ambulatory, or cognitive difficulties.[25] That difference in disability rates meant that the average working-age resident of a non-metro community was 51.4 percent more likely to be disabled than someone of the same age living in a city or the surrounding areas.

FIGURE 4:
Disability Rates in Metropolitan vs Non-Metropolitan Communities, 2013



Source: *Integrated Public Use Microdata Series, American Community Survey, 2013.*
Note: *Sample includes respondents 15-64 years of age that have at least one among the following:*
1.) Independent living difficulty, 2. Self-care difficulty, 3.) Vision difficulty, 4.) Hearing difficulty, 5.) Ambulatory difficulty, 6.) Cognitive difficulty
*** Includes area that are not classifiable as either metro or non-metro.**

TABLE 3:
Recipients of Social Security Disability Insurance Benefits in Metropolitan and Non-Metropolitan Areas, 2013

AREA	RECIPIENTS	SHARE OF SSDI RECIPIENTS	POPULATION (IN MILLIONS)	SHARE OF POPULATION	RECIPIENTS PER 100,000
METRO	6,733,371	77.1%	261.53	83.9%	2,575
NON- METRO	2,005,270	22.9%	50.17	16.1%	3,997
TOTAL	8,738,641	100.0%	311.70	100%	2,804

Source: *Old Age, Survivor, and Disability Insurance (OASDI), Bureau of Labor Statistics, Census Bureau.*

To examine this variable further, we also analyzed the share of people in metropolitan and non-metropolitan areas collecting Social Security Disability Insurance, or SSDI. The program, administered by the federal government, is designed specifically for individuals who have a disability that makes it difficult or impossible for them to work. In 2013, non-metropolitan areas were home to 16.1 percent of the U.S. population. Despite that, they accounted for 22.9 percent of all SSDI recipients. This translated into almost 4,000 SSDI recipients per 100,000 people—far higher than the 2,575 SSDI recipients per 100,000 residents that exist in metropolitan areas. [See Table 3.]

When looked at on the state level, some non-metro areas appear to have both very low levels of home health aide services and a high concentration of either disabled or elderly residents, indicating they may face particular challenges providing enough home health aides to meet local needs. In Alabama, for instance, there are just 35 home health aides for every 100,000 residents in the non-metropolitan parts of the state, the second lowest figure in the country. At the same time, some 5,900 non-metro residents per 100,000 are collecting SSDI, the fourth highest such rate in the country. What's more, while Virginia's non-metropolitan areas lead the country in terms of the proportion of residents that are seniors—20.3 percent of the population there is older than age 65—Alabama's non-metropolitan are not far behind at 17.2 percent. Similar patterns, suggesting high need and low home health aide staffing levels, exist in the non-metropolitan portions of other areas, including Connecticut, Washington, and Vermont. [See Table 4 on the next page.]

In 2013, non-metropolitan areas were home to 16.1 percent of the U.S. population. Despite that, they accounted for 22.9 percent of all SSDI recipients.

TABLE 4:
Incidence of Disability and Density of Senior Population vs Supply of Home Health Aides in Non-Metropolian Areas, by State, 2013

STATE	SSDI RECIPIENTS IN NON-METRO AREAS	RECIPIENTS PER 100,000 IN NON-METRO AREAS	NUMBER OF ELDERLY IN NON-METRO AREAS (IN THOUSANDS)	SHARE OF NON-METRO POPULATION THAT IS ELDERLY	DENSITY OF DISABILITY RANK	DENSITY OF SENIORS RANK	SHORTAGE OF HOME HEALTH AIDES RANK
ALA.	80,565	5,900	112.1	17.2%	4	24	2
ALASKA	4,140	1,733	8.9	7.9%	48	45	42
ARIZ.	13,515	2,840	25.5	14.2%	35	40	4
ARK.	65,850	5,745	82.8	18.3%	7	13	39
CALIF.	33,225	3,996	158.9	19.1%	19	7	25
COLO.	15,330	2,231	39.0	12.1%	43	43	22
CONN.	5,236	4,801	32.4	17.3%	12	23	5
DEL.	6,805	3,296	N/A	N/A	29		32
FLA.	44,250	3,939	18.8	17.6%	22	22	9
GA.	76,900	4,192	66.3	15.4%	16	35	12
HAWAII	9,760	2,313	32.8	17.2%	42	25	27
IDAHO	14,685	2,720	29.9	13.9%	39	42	26
ILL.	52,175	3,164	120.1	18.0%	30	15	20
IND.	52,200	3,730	107.6	15.9%	25	34	35
IOWA	36,030	2,741	88.8	19.2%	38	5	36
KANS.	26,440	2,941	127.5	17.1%	34	27	40
KY.	115,505	6,363	181.7	16.2%	2	31	19
LA.	45,675	3,964	17.1	14.6%	20	39	37
MAINE	32,907	5,761	107.7	19.7%	6	3	34
MD.	8,425	2,683	N/A	N/A	40	N/A	33
MASS.	7,890	9,284	N/A	N/A	1	N/A	14
MICH.	76,365	4,155	307.0	19.1%	17	6	41
MINN.	37,550	2,827	122.4	19.9%	36	2	46
MISS.	83,840	5,151	188.6	14.9%	10	38	15
MO.	73,480	4,832	217.9	17.8%	11	19	11
MONT.	18,195	2,772	46.5	16.7%	37	28	3
NEBR.	18,440	2,444	59.1	17.8%	41	21	7
NEV.	7,970	2,947	26.3	15.4%	33	36	N/A
N.H.	21,292	5,805	85.4	17.8%	5	18	17
N.M.	23,720	3,408	77.2	15.3%	28	37	31
N.Y.	62,210	4,006	130.5	17.1%	18	26	44
N.C.	125,200	4,400	253.3	17.8%	14	20	47
N.D.	7,330	1,962	22.9	18.3%	47	12	23
OHIO	78,760	3,547	323.3	16.4%	26	29	45
OKLA.	53,605	3,959	92.4	16.1%	21	33	30
ORE.	32,740	3,837	86.8	18.9%	23	10	8
PA.	76,705	3,830	191.1	19.0%	24	9	43
S.C.	49,315	4,515	75.6	17.8%	13	17	29
S.D.	9,895	2,179	60.2	16.3%	45	30	21
TENN.	89,240	5,278	141.7	19.0%	9	8	18
TEX.	93,895	3,047	182.1	16.2%	32	32	28
UTAH	7,205	2,223	15.9	11.4%	44	44	13
VT.	16,898	4,379	74.3	18.1%	15	14	6
VA.	58,755	5,314	38.8	20.3%	8	1	24
WASH.	29,315	3,533	72.3	19.6%	27	4	1
W.VA.	48,750	5,990	111.0	18.6%	3	11	38
WIS.	48,665	3,154	132.7	18.0%	31	16	16
WYO.	8,400	2,069	46.9	13.9%	46	41	10

Source: *Old Age, Survivors, and Disability Insurance; Bureau of Labor Statistics; U.S. Census Bureau.*
Note: *Rhode Island, New Jersey, and the District of Columbia are excluded because they do not have any counties classified as non-metropolitan. For some other states, such as Massachusetts, some data is excluded due to the sample being too small to be statistically significant.*

SECTION III: WHY IMMIGRANTS CAN HELP MEET OUR HOME HEALTH AIDE CHALLENGES

As already discussed, the demand for home health aides is expected to spike dramatically in the coming decade. While the creation of more jobs would sound like a positive development for the U.S. workforce, current demographic and aging trends among American workers mean that many of these jobs will be difficult to fill. Home health aides often come from a distinct segment of the American workforce. According to PHI, a group that studies the industry, 91 percent of those working as home health aides are female.[26] Federal studies have indicated that the vast majority of home health aides, or 94 percent, are also low skilled, with less than a college education.[27]

In recent years, however, as college education rates among women have risen, the share of U.S. females falling into such categories has been steadily shrinking. This is particularly true for native-born workers, who currently make up roughly three out of every four home health aides.[28] While just 44.9 percent of U.S.-born women of working age had at least some college education in 1990, by 2010 that figure had surged to 58.7 percent.[29] Looking specifically at native-born, working-age women with less than a bachelor's degree—the population typically drawn to home health aide work—that group shrunk by almost 1.2 million people between 2006 and 2013, dropping in size by 2.5 percent.[30] When immigrant and native-born women are considered together, the population of working-age women with less than a bachelor's degree grew by just 88,000 people during that period, or by less than .02 percent.

If such trends continue in the coming years, this could result in a meaningful mismatch between the needs of the U.S. labor force and the availability of potential home health aide workers. From 2012 to 2022, the U.S. Bureau of Labor Statistics projects that the number of home health aide positions will grow by 48 percent, or 424,000 positions, making the industry the third-fastest growing occupation in the country.[31] Despite that robust growth, however, the population of working-age women with less than a bachelor's degree in the United States will remain relatively stable. If current patterns continue, we project that between 2012 and 2022, the number of native-born women with less than a bachelor's degree will fall by 1.5 percent over the decade. At the same time, the share of working-age women in the country overall, regardless of nativity, will grow by just 2.1 percent.[32] Interestingly, even if the home health aide industry succeeded in attracting more men into the field, finding enough workers would likely still be difficult. Between 1990 and 2010 alone, the number of working-age, less skilled, native-born men in the country dropped by more than 272,000 people.[33]

Such realities will likely result in significant staffing challenges for the home health care industry—particularly among providers in more rural or non-metropolitan settings. Policymakers at the state and federal levels have already taken steps to try to address what many see as an impending crisis in the supply of home health aide workers. In Illinois, Minnesota, and Connecticut, for

TABLE 5:
Number of Working-Age Women with Less than a Bachelor's Degree by Nativity, 2006-2013

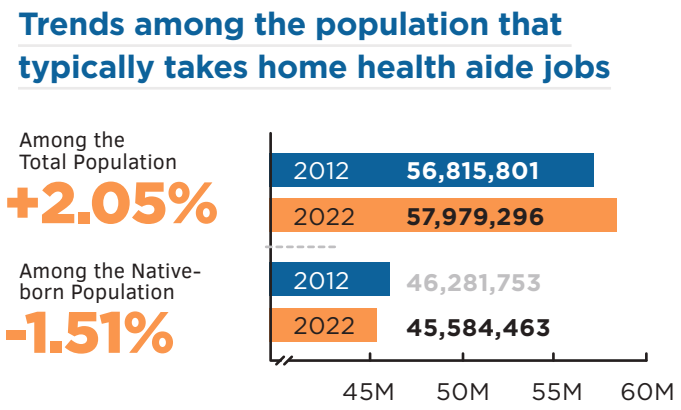
	2006	2007	2008	2009	2010	2011	2012	2013	NET CHANGE, 2006-13	% CHANGE
NATIVE-BORN	47,241,068	47,047,559	47,134,258	46,900,397	46,918,514	46,833,725	46,281,753	46,064,861	1,176,207	-2.5%
FOREIGN BORN	9,332,353	9,474,002	9,496,216	9,742,658	10,334,384	10,452,473	10,534,048	10,596,501	1,264,148	13.5%
TOTAL	56,573,421	56,521,561	56,630,474	56,643,055	57,252,898	57,286,198	56,815,801	56,661,362	87,941	0.2%

Note: *Working Age is defined as those ages 25-64.*

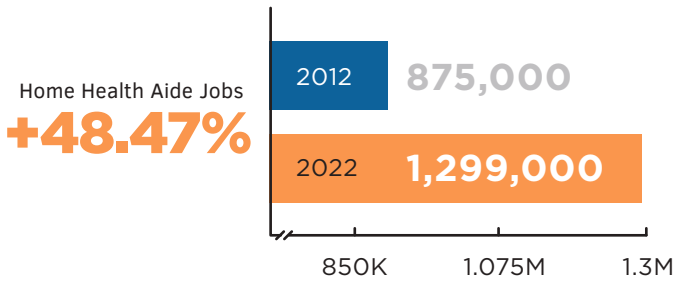
instance, policymakers have allowed home health aides to unionize as public employees, a move that resulted in better training for workers in the industry, and allowed home health aide workers there to command higher wages and healthcare benefits.[34] [35] At the federal level, the White House has taken steps to extend the Fair Labor Standards Act to home health aides as well, a development that would make them eligible for minimum wage and overtime pay.[36] If that move goes into effect, it could help attract more workers to the field—especially given that the average wage for home health care workers hovers at around $21,000 per year, well below the national median of $35,000.[37]

While such efforts will be important to the future of the industry, they have not yet substantially changed the type of workers drawn to home health aide jobs. There is also heavy doubt about whether either initiative will survive court challenges.[38] [39] Last summer, the Supreme Court ruled that home health aides were not full fledged public employees, given that they often work for private firms and households—making organizing them into unions particularly difficult.[40] Federal courts also briefly halted the administration's effort to expand overtime pay and minimum wage requirements to home health aide workers earlier this year.[41] As those efforts falter, the U.S. continues to face unprecedented demographic change. While the population of Americans most likely to need home health care, those aged 85 and older, numbered just 4.7 million people in 2003, the U.S. Census Bureau projects it will grow to 9.6 million by 2020 and soar to 20.9 million by 2050.[42] Given the scale of such population shifts, other avenues must be explored to develop an adequate number of home health aides in the future.

FIGURE 5:
Trends among the population that typically fills home health aide jobs, working-age women with less than a bachelor's degree:



Source: *Author projection using the American Community Survey 1-Year Samples, 2003-2013.*



Source: *U.S. Bureau of Labor Statistics.*

One group that could play a particularly large role in helping fill at least some of the home health aide gaps is immigrant workers. Compared to native-born Americans, immigrants are more likely to be of prime working age, making them good candidates for roles that involve taking care of our rapidly aging population. In 2013, for instance, 79 percent of foreign-born residents in the United States were ages 25 to 64, compared to just 57 percent of U.S.-born individuals.[43]

As larger shares of U.S.-born women gain higher education and graduate to more skilled work, immigrants that choose this field are often willing to do a job that few American workers are interested or willing to do. Home health aide work, which often involves being alone for long periods with disabled or disoriented patients, places major physical and emotional strains on its workers.[44] One large national survey of home health aides found that more than one in nine had been injured on the job in the past year—most commonly due to heavy lifting and back strain.[45] A variety of other hazards, such as needle pricks, violent clients, and even weapons or animal hazards in the home have been described by federal researchers as cause for concern.[46] All of this, combined with long hours, has led the profession to consistently have lower job satisfaction than other major healthcare roles.[47] One national industry survey found a turnover rate greater than 60 percent last year.[48]

Despite such factors, there is evidence that immigrants are interested in home health aide positions. Currently, almost one in four home health aides, or 24 percent, are foreign-born,[49] despite the fact they make

up 16.5 percent of the working age population.[50] In general, they report high job satisfaction, with 70 percent of foreign-born health aides in national surveys saying they feel "very confident" in their abilities on the job.[51] The tendency of immigrants to fall either on the low or high-end of the skills spectrum—with most having either a graduate degree or less than a high-school diploma—also means that home health aide positions are a good complement for their underlying skills.[52] A 2012 study by the Partnership for a New American Economy and Brookings echoed this point, finding that almost one out of every five immigrants in the healthcare industry were home health aides—almost double the rate for native-born workers in healthcare.[53] More immigrants worked in home health aide work than any other healthcare occupation, followed by registered nurses and physicians and surgeons.

The U.S. visa system, however, is not set up to allow immigrants to easily fill home health aide jobs that native born workers are not available or interested in doing. While the H-2A visa program exists for agriculture laborers, and the H-2B program allows the hospitality and entertainment industry to bring in less-skilled individuals for high season work, the United States currently lacks any sort of temporary visa for less-skilled healthcare workers, who make up the fastest growing employment category in the country. As for permanent visas, or green cards, only 5,000 are available to less-skilled workers each year—a heavily restricted supply that leads to long backlogs.[54] The failure of Congress to address the status of the 11 million undocumented immigrants currently in the country hurts the industry further. A study by researchers at Georgetown University found that 21 percent of foreign-born workers with jobs as either home health aides or personal care workers, a similar profession with slightly fewer medical responsibilities, are undocumented immigrants.[55] Their status means that at any time they could be subject to deportation or other uncertainties in their status—a reality that undermines the stability of the thousands of families that depend on them.

An immigration policy that focused more on specific geographies or the needs of the labor market could also be greatly helpful to the home healthcare industry, particularly the non-metropolitan areas already struggling to find enough caregivers highlighted in this report. In both Canada and Australia, programs exist that allow provinces or states to recruit and sponsor the immigrant workers they specifically need. The province of Alberta, Canada, for instance, is currently using its locally targeted program to recruit long-haul truck drivers, industrial butchers, and room attendants at hotels.[56] In Victoria, Australia, industrial engineers, midwives, and air conditioning mechanics are eligible for state visa sponsorship.[57] A similar program would allow non-metropolitan areas to be more responsive to specific labor needs, potentially letting them recruit home health aides and other desperately needed caregivers.

PERSONAL FOCUS: HOME HEALTH AIDE ROELLA HOULLAND

Marvin Fagg is just one of many American consumers whose life has been changed for the better by an immigrant home health aide. Marvin lives in Philadelphia with his mother, Nellie, who is 91 years old. She has dementia, and, as a result, requires constant care and support. However, because Marvin suffers from kidney failure and is still recovering from a serious back injury, it is virtually impossible for him to take care of his mother on his own. A few years ago, Marvin decided to hire a home health aide, Roella Houlland, an immigrant from the Philippines who has looked after his mother for the last two years.

The Faggs and Roella have a special relationship—they have been next-door neighbors since Roella moved to the United States five years ago, meaning that they knew each other well before Roella started working as Nellie's home health aide. This, Marvin says, explains why "theirs is more of a granddaughter-grandmother relationship than anything else." Marvin describes Roella as a talented home health aide, who is "extremely trustworthy, honest, kind, caring and hardworking." "She is proficient and professional, and takes very good care of my mother," he adds.

Roella, who is 37 years old, speaks equally fondly of the Faggs. Although she worked as a computer technician in the Philippines, when she moved to the United States she had to find another profession. She began training as a home health aide two years ago and, immediately afterwards, began working with Ms. Fagg. "We have a good routine," Roella says, "we work together like a family, and when she is happy, I'm happy," she adds. Their close relationship means that, even during her "off" hours, Roella will go round the house to check on Nellie and make sure she is doing well. "It's not about the job. It's about being a Good Samaritan and genuinely caring for your patient. And when that happens, I feel great," she says.

SECTION IV: CONCLUSION

As this brief demonstrates, the United States currently faces a shortage of home health aides that disproportionately affects non-metropolitan communities. Such areas, outside of our big cities and suburbs, have roughly 20 percent fewer home health aides per capita than metropolitan communities. They also have far greater health needs. Their working-age residents are 51 percent more likely to be disabled than those who live in metropolitan areas. And while only 8.2 percent of the U.S. population overall lives in such non-metropolitan communities, they are home to 10.2 percent of the nation's elderly.[58]

Immigrants, as discussed in this brief, are already playing a large role in helping to fill the gaps in our home health aide workforce. In the coming years, however, the country will face unprecedented aging challenges. Between 2000 and 2030, the size of the population aged 65 and older is projected to more than double, growing from 35 million to 71.5 million. Such aging trends will cause the number of home health aide positions to grow by 48 percent between 2012 and 2020. As this demand surges, it is crucial that politicians do more to create channels that would allow home health aide agencies to more easily recruit and bring in immigrant home health aides to fill positions few Americans are eager or interested in performing. Many of our current immigration policies for less-skilled immigrants—including the H-2A visa for agriculture workers and the H-2B visa for hospitality workers—were designed in 1986 to answer the needs of our economy in that era.[59] Today, the aging baby boomers are dramatically reshaping our society and the types of workers that will be needed in the future. It is imperative that our immigration system be rethought to deal with what is arguably the greatest labor challenge of our time.

There is no doubt that our current failure to help bolster the home health aide workforce is also hurting America's seniors. Some studies have found that high turnover in nursing home settings directly impacts the health outcomes for patients.[60] [61] For those seniors suffering from dementia, constant changes in staff and caretakers can also aggravate disorientation and cause undue frustration.[62] Although data in private homes is harder to track, there is reason to believe that similar dynamics could be at play in home-care settings. Finding caretakers eager to take on the work and remain in the positions for the long term then is critical to ensure that today's seniors—and the baby boomers who will be seniors soon—get the care they need and deserve as they age. It can also ensure that older and disabled patients living in more rural communities have the same access to quality care as those choosing to age in our major cities and surrounding suburbs.

Between 2000 and 2030, the size of the population aged 65 and older is projected to more than double, growing from 35 million to 71.5 million.

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