

CARE WORK IN MASSACHUSETTS

*A Call for Racial and Economic
Justice for a Neglected Sector*

BOSTON
INDICATORS

 SkillWorks

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Acknowledgments

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BOSTON INDICATORS

About Boston Indicators

Boston Indicators is the research center at the Boston Foundation, which works to advance a thriving Greater Boston for all residents across all neighborhoods. We do this by analyzing key indicators of well-being and by researching promising ideas for making our city more prosperous, equitable and just. To ensure that our work informs active efforts to improve our city, we work in deep partnership with community groups, civic leaders, and Boston's civic data community to produce special reports and host public convenings.



About Skillworks

SkillWorks is a nationally recognized workforce funder collaborative and public/private partnership between the Boston Foundation and the City of Boston, launched in 2003 to improve workforce development in Boston and across the Commonwealth. SkillWorks brings together philanthropy, government, community organizations and employers to address the twin goals of helping low-income individuals attain family supporting jobs and businesses find skilled workers.



About the Boston Foundation

Founded in 1915, the Boston Foundation is one of the most influential community foundations in the country. Partnering with community members, donors, the public sector, businesses and nonprofits, we aim to repair past harms and build a more equitable future for our city and region. Supported by the Annual Campaign for Civic Leadership, we publish research into current critical issues, convene people in public forums to discuss the city's agenda and the region's trends—and use our shared knowledge to advocate for public policies that promote equity and opportunity for everyone. TBF is also one of New England's largest grantmakers, supporting nonprofits in Greater Boston through our endowment and working closely with our donors to support nonprofits locally, nationally and internationally.

Preface

If we paid jobs according to their value to society, few people would make more than child-care workers, home care workers, and long-term care facility workers. Almost none of us will get through life without needing at least one of them. Demand for the jobs may shift, but it never goes away, and they are impossible to outsource. During the height of COVID people in these roles were some of the first workers to be dubbed “essential.” At this point, we all have first-hand experience with how deeply these jobs undergird all of our society and economy.

Despite all this, it is increasingly difficult for workforce development to recommend jobs in the care economy. Vital though the jobs may be, the practitioners often find themselves doing demanding physical labor at wages that keep them trapped in cycles of poverty. How does work so important get valued so little?

Sadly often in America, how much a job pays is determined not by what it does, but rather by who does it. So it is that care economy workers get underpaid not only because they do what society has historically (and currently) seen as “women’s work,” but because these particular jobs encompass work that would have been done from the era of slavery to today by women of color. The interlocking systems of patriarchy and White supremacy have long kept a lid on wages and job quality for these workers.

I won’t sugar-coat it: This report paints a dire picture for anyone who wants an equitable workforce and society. SkillWorks, Boston Indicators, and all of the Boston Foundation ecosystem have committed to Our New Pathway putting equity at the center of our mission. In SkillWorks’ new strategic plan, that means identifying places where systems of oppression still harm the well-being of workers and dismantling them.

The story this report tells is a grim one, but I hope it’s the final chapter of the old story. We have a moral and economic imperative to plot a new path. Nothing about our legacies of racism and sexism are written in stone. As a community we have the tools to treat this work and these workers with the respect they deserve. It’s not easy to overcome 400 years of systemic oppression and, given the nature of the market for the care economy, it will require both private and public sector commitments. But if we’re serious about racial, gender or economic justice it’s a task we must take up together. As Maya Angelou says, “When you know better, do better.”

Andre Green

Executive Director, SkillWorks

INTRODUCTION

Care work has forever been critical to the health and basic functioning of our society. With the steady aging of our population, care jobs are also among the fastest growing in our economy.

Today these jobs are staffed predominantly by immigrant women and women of color, so despite their societal importance, racial prejudice and gender discrimination have led to a systematic devaluation of care work. These workers tend to receive low wages, enjoy fewer basic benefits like employer-provided retirement plans, face harsh working conditions, and are exposed to high rates of occupational injury.

Nothing made the importance—or precarity—of care work clearer than the COVID-19 pandemic. As infection rates skyrocketed in long-term care facilities, working in a nursing home became more dangerous than logging or commercial fishing. Many early education and child-care facilities closed permanently, and families, including essential workers, scrambled to find care for young children. Adults in need of care struggled to find home care aides so they could safely stay in their homes. Care workers who remained employed faced high levels of COVID exposure and increasingly stressful work for often low pay. The pandemic shook an already teetering care infrastructure.

We hope that the data and analysis in this paper serve as a call to action; anyone seeking to advance racial and economic justice ought to place strategies for improving the quality and conditions of care work near the top of their policy agenda. With this in mind, we organize this paper into the following sections:

- 07 A Brief History of Care Work and Race
- 09 Projected Demand for Care Work
- 11 Demographic Profile of Paid Care Workers
- 14 Job Quality Analysis of Care Work
- 18 Unpaid Care Work
- 20 Concluding Policy Thoughts

Care workers provide supports that every person requires at some point, whether in infancy, illness, disability, or old age.

Throughout this paper we focus on three specific categories of care workers: 1) home care workers, which includes people working independently and paid through MassHealth (called Personal Care Attendants in Massachusetts) and those employed by a home care agency; 2) long-term care facility workers; and 3) child-care workers.^a

We chose to focus on these fields because they are an often overlooked backbone to our social and economic structure, tend to pay lower wages than many other care professions and, owing to the legacy of racial and gender discrimination detailed later in the paper, tend to be fields where Black women, women of color, and immigrant women are concentrated.

a. Home care workers are defined as workers in private households, individual and family services, and home health care North American Industry Classification System (NAICS) industries who are identified as having the following Standard Occupational Code (SOC) occupations: health aide, personal care aide, nursing assistant, or orderlies and psychiatric aide. Long term care facility workers are workers in nursing care facility and residential care facility NAICS industries who are identified as having the same SOC occupations above. Child-care workers are workers identified as having the child care SOC occupation, regardless of industry.

Three main categories of care work in this report:



HOME CARE WORKERS



LONG-TERM CARE FACILITY WORKERS



CHILD-CARE WORKERS

A BRIEF HISTORY *of Care Work and Race*

Scholarship throughout the late 20th and early 21st century has exposed the cultural and economic dynamics that have led to the inequities in caregiving that we have today.

Feminist scholars like sociologists Evelyn Nakano Glenn and Mignon Duffy and legal scholar Dorothy Roberts have delved into the history of care work and its relationship to race. Their work, among many others', demonstrates how care work has been differentially distributed along racial and ethnic lines ever since slavery and how the current undervaluing of care work has long been rooted in structural racism and misogyny. Throughout this section we rely heavily on their scholarship.

Before the Industrial Revolution in the United States, care work was almost exclusively performed in the home by women. Society obliged women, by their position as wife, mother, daughter, or sister, to prioritize caregiving for their kin. As is the case today, the context in which women performed care work differed greatly by class and race. Many enslaved Black women were forced into domestic and care roles that were physically taxing, placed them at high risk for abuse of all forms, and denied them the ability to care for their own family. At the same time, wealthy White women's care work became idealized in popular culture as a symbol of virtue, nurturing, and domesticity—and standing in contrast to the “public” sphere reserved for men.¹

This early division between care provided by women of color and care provided by White women of means set the stage for patterns that we see later in this report. The hard reality of caring for children, the sick and the elderly was in many ways at odds with the ideals of White womanhood, and ultimately it was the labor of enslaved Black, poor, and immigrant women that resolved this contradiction. Well-off White women became responsible for the work that required “moral character and relational skills” (for example, supervising domestic work and serving as a hostess). By contrast, enslaved Black women and domestic servants became responsible for the most difficult and unpleasant work like cleaning floors or performing nursing tasks.² White women became the “public face” of care work, performing jobs that required the most external interaction, while Black women and other women of color became responsible for the “dirty, back-room” jobs like laundry.³

The assignment of Black and other women of color to particularly difficult forms of care work continued through the late 19th and early 20th centuries. Following Emancipation, many Black women in the South were forced back into care jobs through labor agreements that closely mirrored slavery (exploitative tenancy agreements, convict leasing following harsh sentences for petty crimes, and vagrancy statutes that compelled labor to repay steep fines for “idleness”). In the North and Midwest, Black and Indigenous women were excluded from better paying and less physically demanding jobs, such as clerical work or retail, and instead concentrated in domestic labor. And in the West and Southwest, Chinese, Mexican and Indigenous women were channeled into domestic labor, including in commercial laundries or as maids.⁴

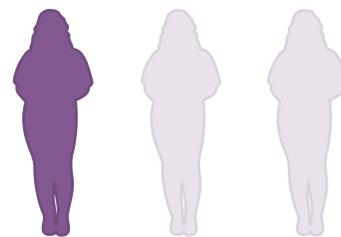
The rise of modern medicine in the late 19th century shifted some care work from the home to hospitals and nursing facilities, and yet the racialized and gendered division of labor persisted.⁵ As the number of hospitals proliferated in the early 20th century, medicine became increasingly professionalized, and technology continued to evolve, more care work positions developed, such as certified nursing assistants and licensed practical nurses. Even as Black women and other women of color were pushed into the most time-consuming and physically taxing positions, they were also viewed as “deficient” mothers because they were unable to live up to the ideal of full-time motherhood. This catch-22 persists in the present day, as poor single mothers are viewed as inadequate or somehow to blame for their poverty. The deep racial prejudice that many people hold against Black and Brown mothers is one reason why the American welfare state is so limited compared to those of other developed nations.⁶

Home care workers were largely left out of early 20th century labor reforms that modernized worker and employer relations.

Glenn writes that the home was often regarded as “off limits to public regulation” because it was viewed as a separate sphere from the market. As such, legislatures and courts often treated paid care workers as if they were “quasi-family members rather than as fully autonomous workers.”⁷ The National Labor Relations Act of 1935, also known as the Wagner Act, affirmed the right of workers to form and join unions, but notably left out domestic workers. The Fair Labor Standards Act (FLSA) of 1938, which established a federal minimum wage, excluded service occupations and thus left out most women workers.

In 1973, amendments to the FLSA extended protections to retail, service, and some domestic workers but a “companionship” exemption excluded those caring for children, elder adults, and adults with disabilities. This seemingly small exemption was ultimately interpreted broadly to include care workers in both home settings and assisted living facilities, including certified nursing assistants, home health aides, and personal care aides.⁸ It was not until 2015 that federal protections were extended to include most care workers.

Demographic, technological, and cultural changes in the United States led to increased demand for care work throughout the 20th century. The growth in average life expectancy, from just 47 years in 1900 to 78 years in 2004, led to greater need for elder care, both in home and institutional settings.⁹ More women began to enter the paid, out-of-home workforce in the mid-20th century, and the full-time, unpaid labor they’d previously provided was often filled by women of color and immigrants. Growing demand for care work has led to an increased reliance on immigrant workers. In 2020, one in five child-care workers nationally and roughly one third of home care workers were born outside of the United States. Many immigrants have limited professional options in the United States due to language barriers, discrimination, or their immigration status, leading them to accept care jobs even if they are overqualified for them.¹⁰ Limited immigration pathways for care workers mean that many foreign-born care workers are on dependent visas, “cultural exchange” visas or are undocumented—all statuses that place them at greater risk for exploitation.



1 in 3

Home care workers born outside of the United States in 2020.

PROJECTED DEMAND *for Care Work*

With the aging of the Baby Boom generation, the number of retirees in Greater Boston is expected to grow by more than 50 percent between 2020 and 2040 (from approximately 689,000 residents over age 65 to a little more than one million).¹¹ Nationally, the number of adults 85 years and older is expected to triple from 6.7 million in 2020 to 19 million in 2060.¹²

The rise in adults over the age of 85 is especially notable because disability incidence increases with age. One in three Massachusetts residents between the ages of 80 and 84 have two or more disabilities, and for those aged 85 to 89 the share is closer to 45 percent.¹³ In addition, a recent AARP study found that 77 percent of adults 50 years of age or older wish to remain in their homes as they age, suggesting that demand for home-based care will grow even faster.¹⁴

Growing demand for paid care workers in the future will compound current shortages.

In February 2020, before the pandemic began, the Boston Globe reported that the vacancy rate for certified nursing assistants was 17 percent, almost triple what it was a decade ago. The pandemic only exacerbated these shortages.¹⁵ According to the Kaiser Family Foundation, 28 percent of nursing facilities surveyed through the CDC National Healthcare Safety Network reported at least one staffing shortage in March 2022.¹⁶

50% +

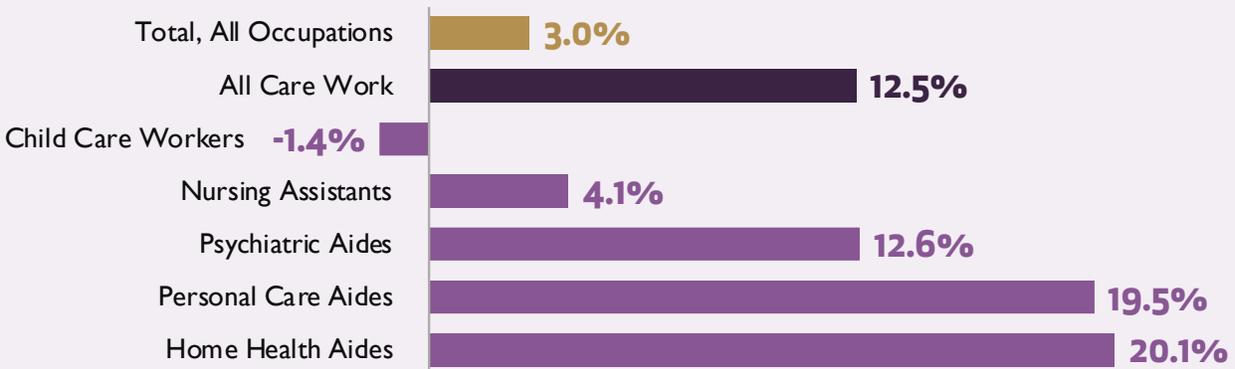
Expected growth of the number of retirees (65 years or older) in Greater Boston from 2020 to 2040

3x

Estimated national growth in the number of adults 85 years and older from 2020 to 2060

Care work jobs are expected to grow significantly by 2028.

Projected percent change in employment levels, by occupation. 2018 to 2028.



SOURCE: MA Executive Office of Labor and Workforce Development Labor Market Information Long-Term Occupation Projections [\[view online\]](#)

Care work occupation growth is expected to outpace overall job growth in the next six years.

Using projection data from 2018, we estimate that care jobs are expected to increase 12.5 percent by 2028, while jobs overall are only projected to increase 3 percent. Personal care and home health aide positions are expected to grow by nearly 20 percent, making it one of the fastest growing occupations in the labor market. It should be noted that the state's Executive Office of Labor and Workforce Development (EOLWD) just released new occupation projections for growth between 2020 and 2030, but because they use base employment levels from the trough of the COVID recession in 2020, those projections show confusingly high growth rates for 2030. So instead, we rely here on these projections that predate the pandemic.

Although demographic trends would point to decreased demand for early education and child-care workers, in reality, demand for early education and child care currently far exceeds supply. Before the pandemic, there were not enough child-care seats in Boston for estimated demand and the pandemic taxed the child-care system even further.¹⁷ Many centers were unable to reopen after mandated closures early in the pandemic and many staff quit as

the pandemic wore on. According to the University of California Berkeley's Center for the Study of Child Care Employment, the national child-care workforce was still down 12 percent in June 2022. Demand for child care remains high and will continue to exceed supply until major changes are made.

The local labor market has relied on immigrant labor for some time, and there is a growing mismatch between demand for care work and declining immigration to the state. Immigrants, particularly immigrants of color, drove Greater Boston's population growth between 1990 and 2019, accounting for almost 90 percent of net population change during that period. Slowing immigration during the Trump administration combined with international travel restrictions during the pandemic have led to declining immigration rates in recent years. The care work sector, locally and nationally, relies heavily on immigrants and it is unlikely that the local labor market will meet the demand for additional care workers. We need to improve care work job quality to make these jobs more broadly appealing to all, while also opening immigration pathways to both help fill this growing shortage and ensure that immigrant workers are less vulnerable to exploitation.

DEMOGRAPHIC PROFILE

of Paid Care Workers

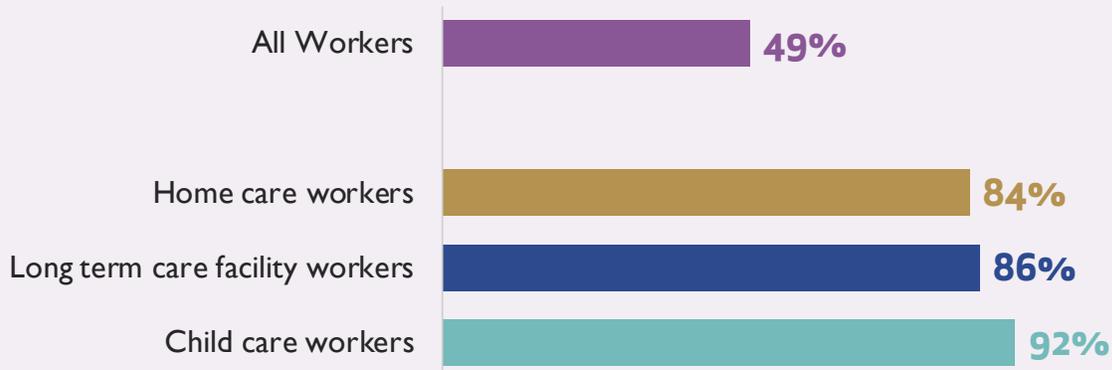
As is the case nationally, care workers in Massachusetts are overwhelmingly women and disproportionately workers of color.

While women make up 49 percent of the workforce in Massachusetts, they account for approximately 85 percent of home care and long-term care facility workers, and 92 percent of child-care workers. At the national level, Asian American and Pacific Islander women make up just 3.3 percent of the workforce, but account for 7 percent of home care workers.¹⁸

For home care and long-term care facility workers in Massachusetts, Black and Latinx workers are most overrepresented. Latinx workers are 11 percent of all workers in Massachusetts, but account for 21 percent of all child-care workers and 27 percent of all home care workers. While Black workers make up just 7 percent of the workforce in the state, they account for 24 percent of home care workers. Black workers make up a staggering 43 percent of long-term care facility workers—approximately six times their share of the total workforce. The vast overrepresentation of Black workers in home care and long-term care facility work reflects the long history described earlier of racial and gender discrimination that has relegated Black women to the most physically taxing direct care jobs.

Care workers are overwhelmingly women.

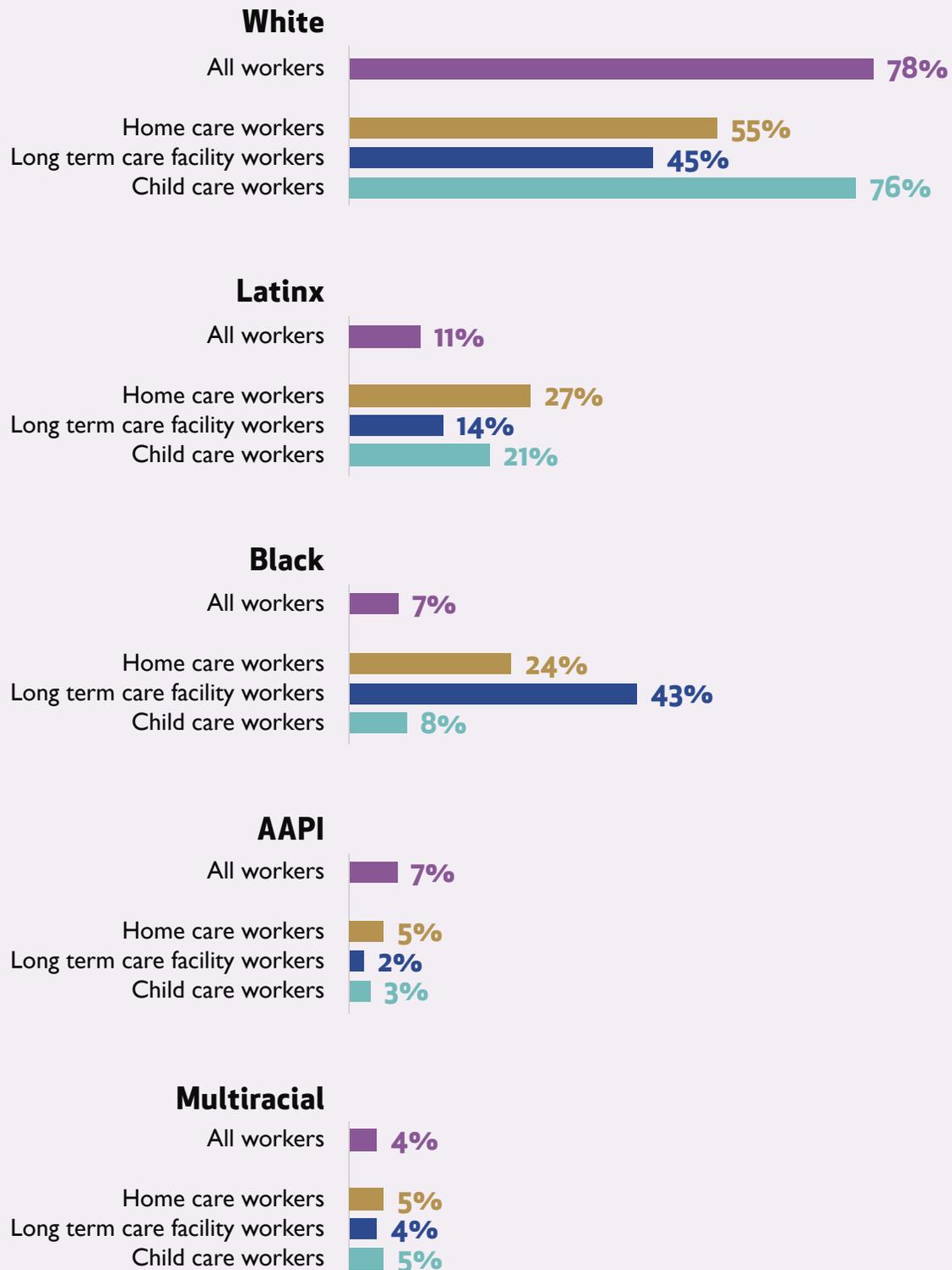
Share of workers in a given occupation that identify as female. Massachusetts. 2016-2020.



SOURCE: 2016-2020 American Community Survey Public Use Microdata

Black and Latinx workers are overrepresented in care work.

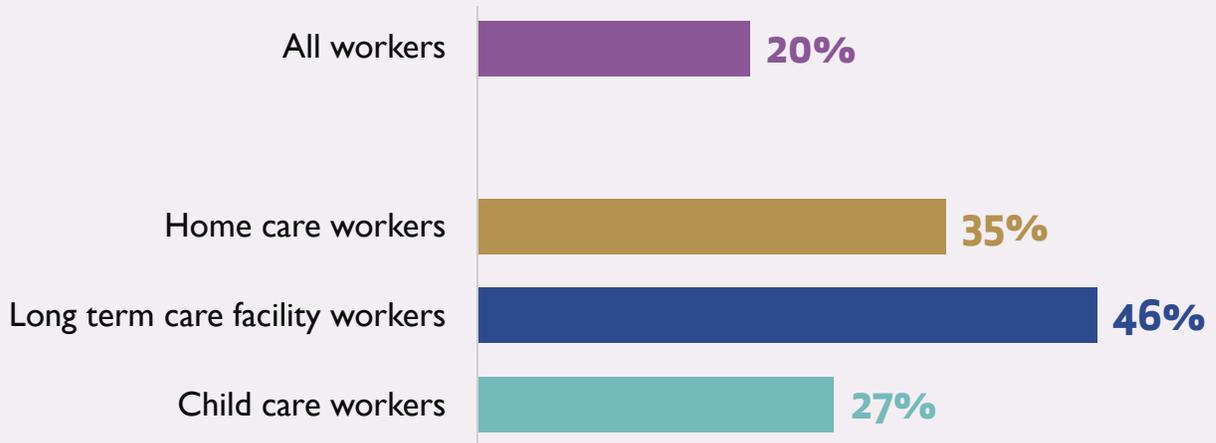
Share of workers in a given occupation by race/ethnicity. White, Asian American Pacific Islander (AAPI), and Black categories are single-race only and Latinx-inclusive. Latinx can be of any race. Massachusetts, 2016-2020.



SOURCE: 2016-2020 American Community Survey Public Use Microdata

Care workers are more likely to be foreign-born.

Share of workers in a given occupation that were born outside of the United States (foreign born). Massachusetts. 2016-2020.



SOURCE: 2016-2020 American Community Survey Public Use Microdata

Care workers are also significantly more likely to be immigrants. While one fifth of workers in Massachusetts were born outside of the United States, one quarter of child-care workers, one third of home care workers and almost one half of long-term care facility workers were. Nationally, the number of Black immigrants in direct care grew 56 percent from 2005 to 2015.¹⁹

While the clear topline trend is that immigrant women of color are significantly overrepresented in care work, specific findings vary a bit by subsector: Child-care workers, for instance, more closely mirror the racial distribution of the state's workforce, and this is the one subsector with a significant share of White workers (at 76 percent). On the other hand, though, women of any background are vastly disproportionately working in child care, with 92 percent of all child-care workers being women. Additionally, while the share of immigrants in home and long-term care facilities is almost double their share of the total workforce, just 27 percent of child-care workers were born outside of the United States.

JOB QUALITY *Analysis*

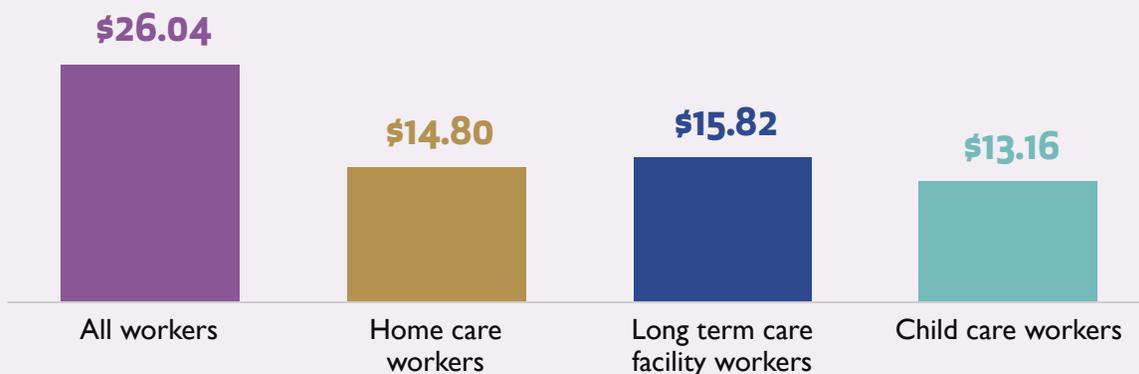
Despite the critical functions provided by these workers and despite the public praise heaped onto essential workers during the pandemic, workers in each of this report’s three care subsectors are near the bottom of the wage distribution for all occupations in Massachusetts.

In fact, they each earn little more than half the average hourly wage statewide, as shown in the graph below. This analysis relies on median hourly wage estimates using American Community Survey data collected over the 5-year period from 2016 to 2020.

Due to the multi-year lag, all estimates are lower than prevailing wages in each sector as of August 2022, making this data more useful for relative comparisons across sectors than it is for any present-day comparisons. In fact, wages have risen quickly across the economy over the last two years (although rising inflation has cut into these wage increases). Many lower-wage workers, for instance, received raises as the state’s minimum wage rose to \$14.25 an hour and as ARPA funding helped support rate increases for care workers paid through Medicaid. As an example of more current estimates of care work wages, based on conversations with industry leaders, wages in long-term care facilities are now closer to \$18 per hour. Additionally, Personal Care Assistants (PCAs) are unionized and recently bargained for a set hourly minimum wage of \$17.75 that is also higher than the data shown in the graph below.

Care work hourly wages are low.

Median hourly wage estimates using pooled data from 2016-2020, Massachusetts. This is the best available data for comparisons across the economy, but due to the multi-year lag, all estimates are lower than prevailing wages in each sector as of August 2022. See report text for examples of current wages in a couple of sectors.



Hourly wage calculated by using annual earnings, usual hours worked per week, and number of hours worked over the past year. ACS reports the number of weeks worked as an interval (range) so the midpoint was used.

SOURCE: 2016-2020 American Community Survey Public Use Microdata

It is also important to note that in our analysis the “home care worker” category includes both PCAs, who are independent home care workers paid by Medicaid (MassHealth), as well as those that are employed by a home care agency. Unlike employees of home care agencies, PCAs exclusively serve MassHealth (Medicaid) enrollees and are thus paid by the state.

This first wage comparison is a straightforward one since it compares care workers to everyone else working in our state economy, but Massachusetts care workers also earn less than workers in jobs that require a similar level of educational attainment. In Massachusetts, for example, electricians earn \$30.34 per hour, more than double what child-care workers earn. This large disparity exists even though both occupations require a high school degree or less.

Notably, however, 99 percent of electricians are men, and 92 percent of child-care workers are women, putting hard numbers to the historic devaluing of so-called women’s work like caregiving, as discussed above.

Of course, broad categories like “high school degree or less” do not perfectly control for all types of education or training. Some union jobs, for instance, may involve more extensive training and certification than other jobs that don’t require formal education beyond high school. But these training differences likely do not explain the large gaps shown below. In fact, most people in the below occupations receive some sort of job-specific training or certification, so it’s not necessarily the case that higher-wage, more male-dominated occupations involve more extensive occupation-specific training. The clustering of women in lower paid positions also persists in occupations that require a bachelor’s degree or higher.²⁰

Among occupations that require a high school degree or less, predominately female ones tend to pay less.

Median hourly wage compared to the share of workers in a given occupation that identify as women. Circle size indicates total number of workers. Limited to occupations with 10,000 workers or more where the median level of educational attainment is a high school degree or less. Massachusetts.



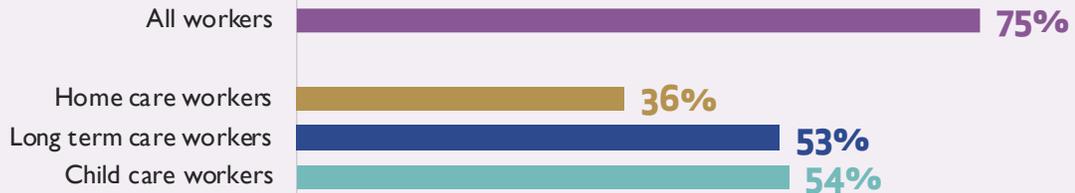
Median hourly wage is calculated by dividing annual wage or salary income by usual hours worked per week and the number of weeks worked over the past year. Because the number of weeks worked is an intervalled variable, the midpoint of each interval was used.

SOURCE: ACS 2016-2020 PUMS

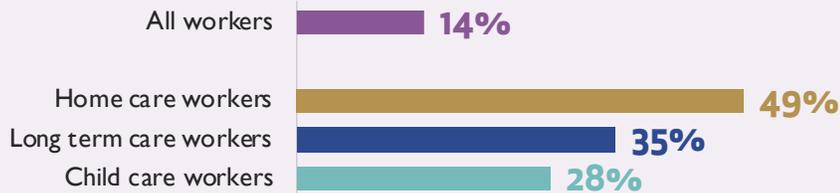
Care workers are less likely to receive employer benefits.

Share of workers in a given occupation who receive health insurance through their providers and share of workers who receive Medicaid. Massachusetts. 2016-2020.

Receives employer-provided health insurance



Receives Medicaid



SOURCE: 2016-2020 American Community Survey Public Use Microdata

Economists have found that even when controlling for the demographics of workers, skills required, qualifications, and characteristics of the job, care workers are still paid 5 to 15 percent less than similar workers.²¹ One study from the Economic Policy Institute found that home health care workers earn 27 to 36 percent less than similar workers who do not work in care.²² Taking these “pay penalties” into account, EPI estimated that a fair and living wage for home health care workers in Massachusetts specifically would be \$28.98—almost double what they currently earn.²³

While good pay is clearly central to any definition of a quality job, care workers’ jobs also tend to be lower quality in other dimensions. For instance, while 75 percent of all workers in Massachusetts receive health insurance through their employer, only about half of child-care and long-term care facility workers do. For home health care workers, it’s even lower, with just about one third receiving employer-based health insurance. This could be due to employees working fewer than full-time hours, either by choice or because their employer only contracts them on a part-time or variable basis. Some home care and child-care workers may be directly employed by individual families who do not offer insurance. Still other care workers may have access to employer-provided benefits but are unable to afford them, making MassHealth the more financially accessible option.

Care workers are also less likely to receive retirement benefits. According to the [Economic Policy Institute](#), home care workers and child-care workers nationwide are much less likely to have a workplace retirement plan—35 percent of the total workforce has a pension or other retirement plan compared to just 10.2 percent of child-care workers and 12.6 percent of home care workers.

Low wages and lack of employer-provided benefits leave many care workers reliant on public benefit programs. Just under 14 percent of all working adults are enrolled in Medicaid (MassHealth), compared to more than a quarter of child-care workers, more than a third of long-term care facility workers, and almost half of home care workers. Further, almost one third of Massachusetts home care workers are enrolled in Supplemental Nutrition Assistance Program (SNAP), the program formerly known as food stamps. Reliance on programs like MassHealth and SNAP can make care workers vulnerable to “cliff effects,” when a small increase in wages can lead to the disproportionate loss of benefits.

Not only are care jobs poorly compensated, they are also physically and mentally stressful. In 2019, [nursing assistants had one of the highest incidence rates of nonfatal injury and illness](#) requiring time away from work (283.5 per 10,000 full-time workers) above heavy and tractor-trailer truck drivers (280 per 10,000) and laborers and freight, stock and material movers (275.5).²⁴ Many tasks performed by direct caregivers put them at risk for injury—such as pushing, transferring and repositioning patients.²⁵

283.5 per 10,000

for full-time workers

Incidence rate of nonfatal injury and illness for nursing assistants—amongst the highest for all professions

Child-care workers were also subjected to higher COVID risk during the pandemic, working directly with small children who were not able to be vaccinated until recently. Even setting COVID aside, they are also exposed to environmental hazards, like bleach or mold, that can worsen or cause respiratory problems. In the early 2010s, 25 percent of child-care and 20 percent of home care workers in Massachusetts reported asthma, compared to just 10 percent of the population overall.²⁶

Care workers often bear high levels of emotional and psychosocial strain. They are frequently responsible not just for the physical well-being of their patients, clients, or young students, but also their emotional well-being and that of their family members. Other psychosocial stressors include few or no decision-making opportunities at work, excessive and/or conflicting demands, frequent interruptions, and difficult work schedules (long hours, evening shift work, lack of rest breaks). These stressors not only engender job dissatisfaction and mental health challenges, but also place care workers at higher risk for chronic health issues such as cardiovascular disease and sleep disruption.²⁷

All these factors fuel care worker burnout. Even before the pandemic, worker turnover rates across all care fields were high. In child-care centers, the turnover rate was estimated to be 30 percent per year.²⁸ Turnover among the home care workforce can be hard to assess but industry leader PHI estimates that annually it is between 40 to 60 percent.²⁹ In nursing homes, the rate is even higher—a recent study estimated the mean turnover rate of nursing staff from 2017 to 2018 to be approximately 128 percent.³⁰ Staff turnover is not only bad for workers, it’s bad for patients, clients, and families. High care worker turnover rates have been associated with lower quality of care in nursing homes, as measured by pressure ulcers and other physical ailments of patients.³¹

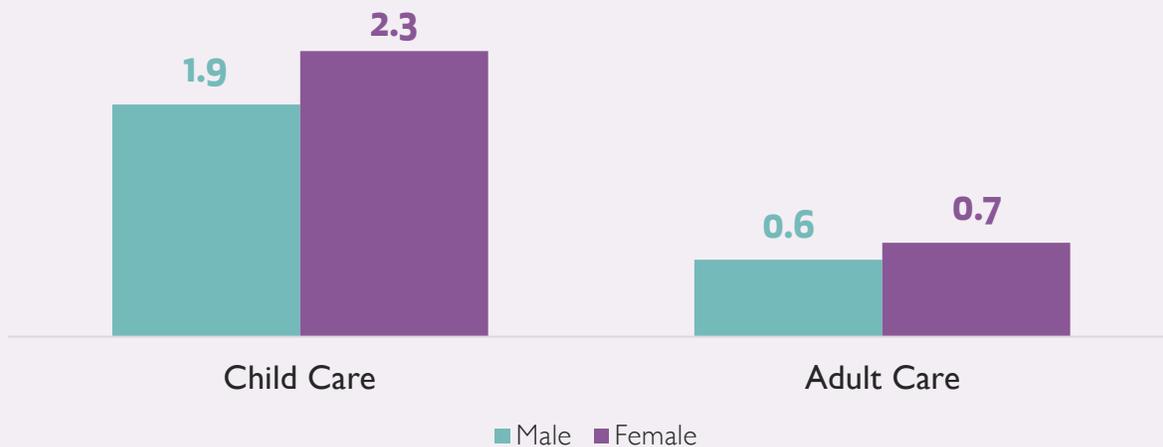
UNPAID *Care Work*

While this paper largely focuses on paid care work, lots of care work is performed at home by family and friends without its being part of any formal job.

According to the American Time Use Survey (ATUS), between 2015 and 2021, 37 percent of working-age (25 to 64 years old) Massachusetts men engaged in direct, unpaid care work for adults or children and 51 percent of working-age Massachusetts women did. Of those who did perform unpaid care work, women spent approximately 0.4 hours (25 minutes) more per day caring for children than men, and 0.1 hours (eight minutes) per day longer on adult care.

Female caregivers typically spend more time performing care work.

Average hours per day spent on caring for household and non-household children and adults. Does not include time spent performing paid care work. 2015-2021 pooled data. Massachusetts.



SOURCE: 2015-2021 American Time Use Survey (ATUS)

Unpaid care work has become more prevalent, more complex, and longer lasting. Nationally, a [2019 AARP survey](#) estimated that the number of adults caring for adults had increased by almost 8 million between 2015 and 2020. The share of unpaid caregivers responsible for more than one person increased to 24 percent, while at the same time caregivers are tackling increasingly complex medical or support needs. Medical technology has evolved such that more people are able to “age in place” or be ill at home—on the whole a good thing—but that often leaves family caregivers to take on increasingly skilled care work that might formerly have been performed by a nurse or nursing assistant, such as changing catheters or managing feeding tubes.³² Finally, as adults live longer, family caregivers are providing this care for longer periods of time. AARP found that roughly one in three family caregivers of adults were providing care for five or more years, up from one quarter in 2015.



8 million

National increase in family care givers between 2015 and 2020



50%+

of family caregivers reported they did not have a choice in taking on a caregiver role

Caregiving can come at tremendous personal cost to family members. More than half of caregivers reported that they did not have a choice in taking on a caregiver role and 36 percent found it to be highly stressful. Family caregivers often report feeling lonely, that they have difficulty taking care of their own health, and that caregiving has negatively impacted their finances.

Of family caregivers surveyed, AARP found that 61 percent were employed while caregiving and that the majority of those have experienced changes to their employment situation as a result of caregiving (leave of absence, going in late/leaving early, reducing hours, turning down promotions, etc).

Many of the challenges facing unpaid caregivers were exacerbated by the pandemic. Paid care aides that help relieve family caregivers may have stopped visiting, causing family to provide 24-hour care. Family caregivers often did not have the same access to personal protective equipment or COVID-19 testing that workers in an institutional setting had, and mental health effects accumulated, particularly for those already prone to isolation, such as [spousal caregivers](#).

It is important to note that paid and unpaid work complement each other. Rather than acting as substitutes, paid care work often supplements care provided by family. Even when a family has paid support, unpaid family members are typically responsible for coordinating care services for kin. Paid care workers may also periodically relieve an unpaid caregiver or perform a specific task that family caregivers are unable to.³³

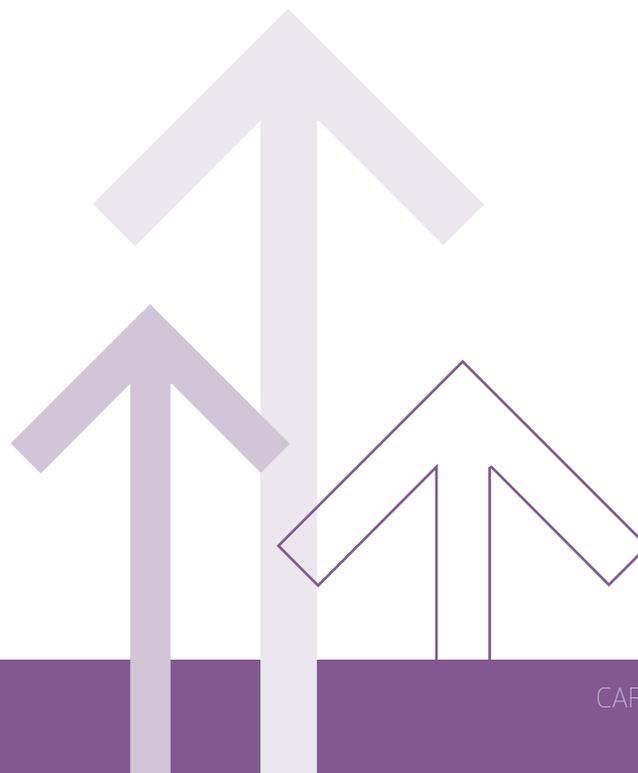
Better valuing unpaid care work and increasing access to care services is also a racial and economic justice imperative. Many unpaid care workers lack access to benefits, like paid time off to care for their loved ones. Black caregivers are more likely to report negative financial impacts as a result of caregiving for an adult family member.³⁴ Expanded access to high-quality and affordable child care would increase lifetime earnings for all mothers, but particularly for Black and Latinx women who are more likely to have lower incomes. A lifetime of affordable child care would lead to an [increase of over \\$100,000 in lifetime net income for Black mothers](#), the highest of any racial or ethnic group.³⁵

CONCLUDING *Policy Thoughts*

Improving the quality of jobs in care work today is critical to advancing racial and economic justice.

Over centuries, policies driven by racism, xenophobia, and misogyny have closed professional doorways and shunted many women of color, particularly immigrant women, into care work, where they contend with low wages, few benefits and challenging working conditions. As this segment of our economy continues to grow, these issues will confront more and more workers until they are addressed.

In recent years, Massachusetts has taken some important steps towards better valuing care work. The state passed a Domestic Workers Bill of Rights in 2014, which guarantees things like minimum rest periods, and we are one of 11 states with a public paid family leave program. But there's much more we can do. So, we end this paper with a brief discussion of a few promising strategies for enhancing care work in Massachusetts. While they are focused primarily on improving the experience of workers, anything we do in this domain will also have the effect of improving the quality of care they provide, as things like turnover and burnout would reduce.

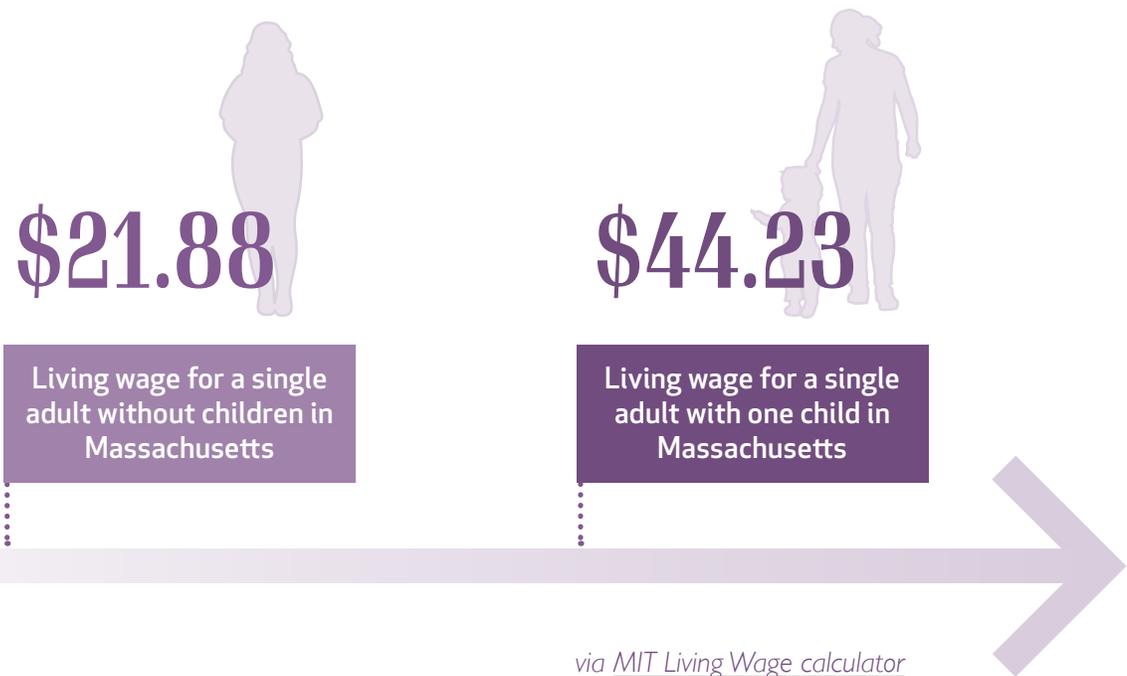




Continue strengthening the state minimum wage.

The state minimum wage is another area where Massachusetts has been a national leader, with advocates successfully pushing the legislature to pass a plan that is gradually phasing up our state minimum wage to \$15 an hour by 2023. Raising the minimum wage helps boost the wages of all lower-income workers, but it is especially important for care workers since they tend to be at the lower end of the wage distribution.

While recent increases have already raised the wages of many care workers in Massachusetts, the current \$14.25 minimum wage remains well below the estimates of what it takes to afford our state's increasingly high cost of living. According to the [MIT Living Wage calculator](#), for instance, a living wage for a single adult without children in Massachusetts is \$21.88 an hour and \$44.23 for a single adult with one child. Raising the minimum wage up to one of these levels immediately could be difficult for employers, but focusing on living wage estimates like these are helpful for setting longer-term goals. Additionally, Massachusetts has not indexed its minimum wage to inflation, so this is an issue the legislature needs to keep returning to in order to ensure that its value doesn't erode over time.





Increase Medicaid (MassHealth) reimbursement rates for Home and Community-Based Services (HCBS) and long-term care facilities.

Simply requiring higher pay from employers can be tough for agencies or institutions working with limited budgets, so it is important to pair regulatory changes like minimum wage increases with expanded public funding to help subsidize these increased labor costs. Most funding for home and long-term care supports flow through Medicaid. One common way of offsetting increased labor costs is for states or the federal Centers for Medicare and Medicaid Services to raise the set reimbursement rates for care. Importantly, steps should be taken to ensure that funds from higher rates go to workers themselves and not to agency administration, such as by setting “permissible uses” of the funds or specifying that a certain percentage of enhanced funds go to worker compensation.

The federal government already provided enhanced reimbursement for HCBS through the American Rescue Plan, and many states, including Massachusetts, used those to raise wages temporarily for direct care workers. Maine announced a similar plan to use ARPA funds to raise care worker wages but did so in a more long-term way—by setting the HCBS worker minimum wage at 125 percent of the state's minimum wage and committing to use state funds to continue the increase after ARPA funding is exhausted.³⁶ While Massachusetts permanently raised Personal Care Attendant wages to \$17.75 in 2022, it could go one step further by following Maine's lead and pegging PCA wages to the minimum wage that is set to rise again in January 2023.



Develop a licensing process for home care agencies.

Currently, home care agencies are not required to register or receive a license from the state. The lack of a licensing process makes it difficult for the state to oversee home care agencies that provide services to those on MassHealth and those paying with private insurance or out of pocket. In 2021, a recently established state Home Care Licensing Commission recommended a licensure framework to cover all home care agencies. A subsequent bill was introduced to the Massachusetts legislature in 2022 but was not passed. Without a licensing process, the state has very limited options to ensure high job quality for workers and high quality of care for consumers who are not on MassHealth.



Improve access to training and career ladder programs.

Increased access to training programs, supportive supervision and mentorship can improve job satisfaction and help improve working conditions.³⁷ Similarly, providing greater opportunities for advancement both within the occupation through specialized credentialing and career ladders, or into similar fields through clear “career lattices” can help attract new workers and improve worker retention.³⁸



Expand the Earned Income Tax Credit (EITC) to include unpaid caregivers.

Massachusetts already provides a refundable EITC to low- and moderate-income working people that matches 30 percent of the federal credit, or a maximum credit of \$2,018 for those with three or more children. But to date, people have to report earned income in order to be eligible, meaning that unpaid caregivers have not been eligible. [State legislation](#) introduced in 2021 would raise the EITC, increase eligibility, and notably, extend the credit to groups that had previously been excluded—including unpaid caregivers.



Refile and pass existing legislation to increase access to early education and child care.

State legislation proposed in 2021, and passed by the Senate in July of 2022, would significantly expand family eligibility for child-care subsidies to include, over time, families that earn up to 125 percent state median income. It would also create a new funding stream to directly support the operating costs of early education and child-care providers. New operational funding would offset the high costs associated with early education and child-care provision and, importantly, help raise educator pay. The legislative framework would build on the fiscal year 2023 state budget, which continues program stabilization grants (originally ARPA-funded) and increases workforce funding through rate increases for subsidized programs.



Pass labor reforms that make it easier for workers to exercise collective power.

By strengthening worker bargaining power, union membership is associated with greater pay and access to benefits. Care workers that are in a union are also more likely to stay in their jobs and receive helpful training.³⁹ Despite this, many care workers do not have access to a union. Care workers employed by an agency, center or institution are more likely to be unionized than those who are independent providers. The state of Washington has notably created a home care public authority that not only runs training and apprenticeship programs, but also allows for a collective bargaining process for independent providers to set rates that were then also applied to agencies. The public authority also offers benefits such as health coverage to both agency and independent workers. Another model for building collective power could be sectoral bargaining, as exists in many European countries, that operates across an entire occupation or industry.



Improve public transit and expand affordable housing opportunities.

The issues may seem beyond the scope of the specific problem at hand—improving care jobs—but on the contrary could be among the most life-changing solutions for beleaguered care workers. The high cost of living in Massachusetts impacts all workers but is especially hard for care workers whose low wages make it difficult to afford housing where demand for their services is often highest. As it stands, many workers are reliant on public transit to travel long distances from where they can afford to live to where they can find a job. Investing in more frequent service, safety improvements to reduce service disruptions, lower fares, and “first/last mile” services are critical to helping care workers do their jobs.

Care work is foundational to our economy, personal health, and community well-being.

Labor shortages, poor job quality, and high rates of occupational illness and injury are not new—they predated the pandemic and reflect a collective failure to value care work. This failure has profound consequences not just for the quality of care that we receive, but also for racial and economic justice. Women of color, particularly Black and immigrant women, are dramatically overrepresented in low-wage care professions. Better valuing care work, both paid and unpaid, would improve financial outcomes and stability for many of these women. It would help push back against the history of structural racism and misogyny that, by constraining their job options and devaluing their labor, has snared countless generations in poverty. The pandemic made the importance of care work undeniably clear. For the first time, care infrastructure is a part of mainstream, public dialogue and it is critical that we do not let this moment pass us by.

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