The Role of Social Work in the Lives of Home Care Workers

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Demand for quality home health care has been growing as more and more persons who are old, chronically ill, or disabled choose to receive long-term care services in community-based, rather than in institutional settings. Home care has been driven by three primary trends: an individual's preference to remain in his or her own home for as long as possible, advancements in medicine and technology which support complex care at home, and a political interest in deinstitutionalization with the goal of containing health care costs (Kaye, Chapman, Newcomer, & Harrington, 2006; Stone, 2004). The Bureau of Labor Statistics (2007) projects that between 2006 to 2016, the demand for home care workers will grow by 50.6%.

Traditionally, social work practice and research in the field of home care have centered upon helping long-term care consumers by responding to their physical, emotional, and social needs (Lee, 2002). Dyeson (2005) described five primary roles of a home care social worker: (a) advocating for consumers, (b) organizing community resources, (c) educating interdisciplinary treatment team members about the role and function of medical social services, (d) providing consultation to team members regarding treatment plans, and (e) helping reduce the overall cost of providing health care.

While these traditional roles continue to be important, given their significant influence on the quality of care consumers receive, there is an increasing need for social workers to engage in promoting the rights and well-being of direct home care workers. On a daily basis, home care workers provide assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) that enable individuals to maintain their health and functional abilities, participate in social activities, and most of all avoid or delay institutionalization (Kaye et al., 2006). Given the intimacy of these close, personal caregiving relationships, home care workers also respond to the affective needs of consumers and family members.

Despite the significance of their work in supporting vulnerable individuals in the most intimate manner, these workers, who are typically low income, minority or immigrant women, are the least valued group of people in the health care industry, in terms of status, salary, and privileges. Within the logic of the business practice, they are treated like a commodity and their physical and emotional needs are largely disregarded (Donovan, 1987; Olson, 2003). In order to draw more attention from social workers to the experiences of this "terribly neglected profession" (Amato, 2004, p. 243), this paper describes the current status and working conditions of home care workers and their effects on the quality of care provided to consumers. It then discusses implications for social work practice in promoting the well-being of home care workers. This, in turn, can have positive consequences for consumer quality of life through improved care.

Status and Working Conditions of Home Care Workers

Low status of the home care workforce reflects the intersecting disadvantages of gender, social class, and race. Care work is traditionally "a taken-for-granted female activity" (Dodson & Zincavage, 2007, p. 906) that receives no social recognition. Particularly home care is often regarded as an extension of ordinary, unskilled domestic labor that has little value and significance (Aronson & Neysmith, 1996). Due to its easy job entry requirements, home care work attracts socially and economically marginalized groups of women with few occupational choices. Compared with all female workers and even with all direct care workers, home care workers are more likely to be minority, foreign-born, who have high school or less education, and who live below the poverty line (Smith & Baughman, 2007). Such socioeconomic characteristics of workers mirror the historical image of women of color working as submissive

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servants in private homes, resulting in a lack of social respect and a negative public perception of the occupation.

Within the health care community, home care workers are at the bottom of the hierarchy. Even though they work most closely with consumers, they usually have no input into care planning, decision making, and scheduling. They receive none or minimal training and supervision and have little opportunity for advancement (Stone, 2004). They are grossly underpaid and earn only $5.41 to 11.38 on the average, which is likely insufficient for an adult with dependent children (Paraprofessional Healthcare Institute, 2008). While their work is physically and emotionally demanding and many of them suffer from job-related injuries and mental health problems, only one-third of them are covered under their own employment-based health care coverage (Kaye et al., 2006). Moreover, they are typically not paid for travel time between jobs and do not have pensions, paid sick leave, paid holiday and vacation time, and gas or mileage reimbursement (Hayashi, Gibson, & Weatherley, 1994).

In their relations with consumers and their family members, they frequently suffer from mistreatment and lack of respect. Working in isolation of individual homes without any immediate support or backup, they are extremely vulnerable to exploitation and discrimination. They are often treated as maids or cleaning ladies and become subject to physical and verbal abuse, sexual harassment, racial discrimination, and unreasonable or inappropriate demands (Aronson & Neysmith, 1996; Ebenstein, 1998; Neysmith & Aronson, 1997; Stacey, 2005). Despite the heavy workload they already have, many of them make personal sacrifices and provide unpaid extra services to meet consumers' needs out of the fear of losing their job as well as a sense of moral obligation (Aronson & Neysmith, 1996). The blurred boundary between formal and informal labor also pushes them to act like a friend or family member of the consumer and take on added responsibilities, all while they struggle to maintain their own household (Stacey, 2005). Consequently, they become physically and emotionally overstretched to the point where they are either no longer able to continue working or providing quality care. Studies have identified high stress levels, low job satisfaction, and high intent to leave the job among home care workers (Denton, Zeytinoğlu, & Davies, 2002; Matthias & Benjamin, 2005)

Effects on Quality of Care

Despite the low social status of the occupation, many home care workers take pride in their job. They are dedicated to helping people and enjoy their close, personal relationships with consumers. They report feelings of fulfillment as they see consumers improve because of their efforts (Ebenstein, 1998). However, current working conditions make it difficult for even the most dedicated workers to stay on their jobs. Stone and Wiener (2001) reported that turnover rates among direct home care workers range from 10 to 76%. Considering the fact that many entry-level positions in fast-food restaurants and retail stores offer more stable, safer, less demanding, and better paying jobs, attracting and retaining workers in this field is obviously difficult (Potter, Churilla, & Smith, 2006). As a result, the long-term care system is experiencing a severe shortage of direct care workers. Vacancy rates of home health and home care agencies range from 14 to 27% (Stone & Wiener, 2001). Nationally there is only one home care worker per ten potential consumers which suggests substantial competition among these agencies to recruit an appropriate number of workers (Kaye et al., 2006).

This situation is causing further deterioration in the quality of work life and in the delivery of care. Care workers are under pressure to increase productivity by accomplishing tasks in a shorter time and by visiting more clients per day. They have fewer mentors and more limited

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time available for on-the-job training and receive little support from supervisors who are themselves overworked (Bureau of Health Professions, 2004). An inability of the workers to provide satisfactory care is making not only the job more stressful, but is also threatening consumer well-being. Care provided in a rushed manner by less qualified workers likely affects consumer safety and comfort. Limited interactions between care workers and consumers hinder the development of trusting, personal relationships. Moreover, turnover causes disruption in the continuity of care and creates extra burdens for consumers who have to orient a new worker and reestablish mutually acceptable care routines (Soodeen, Gregory, & Bond, 2007). The lack of a reliable workforce also causes reduced access to care and may force individuals to choose more restrictive, more costly institutional care (Bureau of Health Professions, 2004). In one study, approximately 29% of adults of all ages with a disability who need community-based services in two or more of the five basic ADLs have unmet needs because of lack of paid help (LaPlante, Kaye, Kang, & Harrington, 2004).

The costs associated with recruiting and replacing workers have also become primary concerns for home care service agencies. A shortage of workers means decreased productivity, service volume, and profits. Agencies have to bear the extra cost associated with turnover including an additional advertisement for recruitment, hiring incentives, orientation activities, administrative resources for separation, and resources for temporary staffing (Bureau of Health Professions, 2004). The direct cost of turnover per care worker is estimated to be at least $2,500 (Seavey, 2004). Cost-cutting efforts of agencies to retrieve this economical loss result in worsening working conditions for their employees, thus further increasing their likelihood of leaving the job.

Implications for Social Work

The quality of work life of care workers and the quality of life of consumers are closely interrelated. As Kane (1994) described, consumers can never be more empowered than those who provide care. Until these workers supporting the long-term care system feel rewarded and motivated to perform their best on the job, social workers cannot ensure the well-being of consumers. With its expertise and knowledge in group work, policy making, and research, social work can make a significant contribution in facilitating necessary changes in the current working conditions of home care workers.

For example, as a social worker, Amato (2004) described her efforts to organize and facilitate a mutual aid group for female home care workers who came to an adult day care center with their clients. The group created an opportunity for these women, who normally work in isolation, to interact with each other and to share their concerns and experiences in a safe and non-judgmental atmosphere. Through the group discussion, they were able to identify issues they were facing and collaboratively engage in the problem solving process. The support group not only satisfied the women's needs to be heard, but it also provided them an ongoing sense of community.

These small group efforts can grow into a larger, collective action to fight for achieving economic and social justice in the long-term care industry. Home care workers have started unionizing for better wages, benefits, and working conditions (Boris & Klein, 2006; Donovan, Kurzman, & Rotman, 1993). Social workers would be better able to influence health care and labor policies if they joined these forces and brought other health care professionals and interest groups together. Donovan and colleagues (1993) described a collaborative project jointly undertaken by a school of social work and a labor union. The school first conducted research to

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identify the demographic characteristics and the health and social needs of union members. Building on the research findings, it then established a union-based social assistance program to address individual needs in the areas of housing, child care, and family issues. At the same time, the union used research data as a foundation for collective bargaining, legislative action, and public education. In the end, the project positioned the union to successfully negotiate for more state funding for home care resulting in increased wages and basic health benefits for workers.

These cases indicate that by working at multiple levels, social work can fulfill its dual commitment to social services and social change (Donovan et al., 1993). By responding to individual voices and incorporating them into policy reform efforts, social work can effectively promote social and economic justice for these neglected, but critically important workers in supporting the long-term care system.

Conclusion

This paper described concerns related to the working conditions of home care workers and called for social work involvement in the efforts to improve their work life. Given the inherent social injustice these workers are experiencing and the significant role they are playing in the daily lives of individuals struggling to maintain care at home, the advocacy for their well-being and rights needs to be a social work priority. Through individual and collective efforts, social work can contribute to creating a system where every person involved in care is treated with respect and human dignity. As a result, social work would be able to ensure a better quality of life for millions of people and fully achieve its mission.

References

Amato, S. M., T. (2004). The use of a mutual aid group with home attendants. *Journal of Gerontological Social Work, 44*(1/2), 243-253.

Aronson, J., & Neysmith, S. M. (1996). "You're not just in there to do the work": Depersonalizing policies and the exploitation of home care workers' labor. *Gender & Society, 10*(1), 59-77.

Boris, E., & Klein, J. (2006). Organizing home care: Low-waged workers in the welfare state. *Politics & Society, 34*(1), 81-107.

Bureau of Health Professions. (2004). *Nursing aides, home health aides, and related health care occupations: National and local workforce shortages and associated data needs*. Retrieved October 30, 2008, from ftp://ftp.hrsa.gov/bhpr/nationalcenter/RNandHomeAides.pdf

Bureau of Labor Statistics (2007). *Employment projections: 2006-16 summary*. Retrieved December 29, 2008, from http://www.bls.gov/news.release/ecopro.nr0.htm

Denton, M. A., Zeytinoğlu, I. R., & Davies, S. (2002). Working in clients' homes: The impact on the mental health and well-being of visiting home care workers. *Home Health Care Services Quarterly, 21*(1), 1-27.

Dodson, L., & Zincavage, R. M. (2007). "It's like a family": Caring labor, exploitation, and race in nursing homes. *Gender & Society, 21*(6), 905-928.

Donovan, R. (1987). Home care work: A legacy of slavery in U.S. health care. *Affilia, 2*(3), 33-44.

Donovan, R., Kurzman, P. A., & Rotman, C. (1993). Improving the lives of home care workers: A partnership for social work and labor. *Social Work, 38*(5), 579-535.

Dyeson, T. B. (2005). The myriad roles of the home care social worker. *Home Health Care Management & Practice, 17*(5), 398-400.

Ebenstein, H. (1998). They were once like us: Learning from home care workers who care for the elderly. *Journal of Gerontological Social Work, 30*(3/4), 191-201.

Hayashi, R., Gibson, J. W., & Weatherley, R. A. (1994). Working conditions in home care: A survey of Washington State's home care workers. *Home Health Care Services Quarterly, 14*(4), 37-48.

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Kane, R. A. (1994). Ethics and the frontline care worker: Mapping the subject. *Generations, 18*(3), 71-74.
Kaye, H. S., Chapman, S., Newcomer, R. J., & Harrington, C. (2006). The personal assistance workforce: Trends in supply and demand. *Health Affairs, 25*(4), 1113-1120.
LaPlante, M. P., Kaye, H. S., Kang, T., & Harrington, C. (2004). Unmet need for personal assistance services: Estimating the shortfall in hours of help and adverse consequences. *Journal of Gerontology: Social Sciences, 59B*(2), S98-108.
Lee, J. S. (2002). Social work services in home care: Challenges for the new prospective payment system era. *Social Work in Health Care, 35*(3), 23-36.
Matthias, R. E., & Benjamin, A. E. (2005). "Intent to stay" among paid home care workers in California. *Home Health Care Services Quarterly, 24*(3), 39-57.
Neysmith, S. M., & Aronson, J. (1997). Working conditions in home care: Negotiating race and class boundaries in gendered work. *International Journal of Health Services, 27*(3), 479-499.
Olson, L. K. (2003). *The not-so-golden years: Caregiving, the frail elderly, and the long-term care establishment*. Lanham, MD: Rowman & Littlefield.
Paraprofessional Healthcare Institute. (2008). *State chart book on wages for personal and home care aides, 1999-2006.* Retrieved September 28, 2008, from http://www.directcareclearinghouse.org/download/PHI_State_Chartbook_PHCA_Wages_99-06.pdf
Potter, S. J., Churilla, A., & Smith, K. (2006). An examination of full-time employment in the direct-care workforce. *The Journal of Applied Gerontology, 25*(5), 356-374.
Seavey, D. (2004). *The cost of frontline turnover in long-term care*. Washington DC: Better Jobs Better Care.
Smith, K., & Baughman, R. (2007). Caring for America's aging population: A profile of the direct-care workforce. *Monthly Labor Review, 130*(9), 20-26.
Soodeen, R-A., Gregory, D., & Bond, J. B. Jr. (2007). Home care for older couples: "It feels like a security blanket…". *Qualitative Health Research, 17*(9), 1245-1255.
Stacey, C. L. (2005). Finding dignity in dirty work: The constraints and rewards of low-wage home care labour. *Sociology of Health & Illness, 27*(6), 831-854.
Stone, R. I. (2004). The direct care worker: The third rail of home care policy. *Annual Review of Public Health, 25*, 521-537.
Stone, R. I., & Wiener, J. M. (2001). *Who will care for us? addressing the long-term care workforce crisis.* Washington DC: The Urban Institute and the American Association of Homes and Services for the Aging.

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