New American Economy | Healthcare

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A Helping Hand

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

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, creating more jobs in fields such as pharmaceutical manufacturing and elder care in preparation for a period of soaring demand.

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But perhaps no other profession will be as profoundly impacted by the graying of America as home health aides, workers who help both seniors and younger, disabled individuals cope with their ongoing 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 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 home healthcare industry has trouble attracting the U.S. workers who do fit this profile, likely because of long hours, the physical and mental challenges associated with the job, and the fact that historically home health aides have been among the lowest-paid occupations in the country. There have been recent attempts to raise the wage of these jobs in several states and, most recently after a federal court ruling, at the federal level.[6] But the evidence from 16 states that already have minimum wage requirements for home health aides suggests that this alone will do little to mitigate against any potential worker shortages. The downsides of this occupation versus other minimum wage roles remain, and the states that have required minimum wage for these jobs still experience huge gaps in the supply of workers, particularly in rural communities.[7]

The population of people who typically fill such jobs is projected to **grow by just 2.1%**.

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 the areas outside of them. 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.

Home health aides care predominately for elderly individuals or patients with disabilities. Both groups are more commonly found outside of metro areas. The average resident in a non-metro community today is 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, Connecticut, 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, as a large portion of Americans age, and as young Americans become more educated, 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.

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.[8] 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 are not available given the limited supply.[9] [10]

In this paper, part of a series on the healthcare workforce, we examine the current population of home health aides and where they are around the country, comparing the differences in supply between metropolitan areas and non-metropolitan, or more rural areas.[11] 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 10.5 million baby boomers and elderly individuals living in such communities particularly vulnerable to healthcare challenges as they age.

Already, some parts of the country are reporting **severe home health aide shortages**.

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.[12] 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.[13] In other words, there is a large pool of immigrants well suited for high-skilled jobs, like physicians or surgeons, but there is also a large pool of immigrants well suited for low-skilled jobs. For this segment of the immigrant population, 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.[14]

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, even when no Americans are interested or available to fill such roles.[15] [16] 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,[17] 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 also present a challenge for the direct care industry overall, where it is estimated that more than one in five immigrant workers are currently undocumented.[18] 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 this increasingly important industry, especially in rural areas where the need for more home health aides is greatest.

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.[19] Many rural communities also face particular challenges providing their populations with adequate numbers of dentists and mental health professionals.[20] [21] 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, the number of jobs in the industry are projected to grow by 48 percent between 2012 and 2022.[22]

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 2013 American Community Survey 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.[23] 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.[24] Our work shows non-metropolitan areas are likely being hit disproportionally 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.

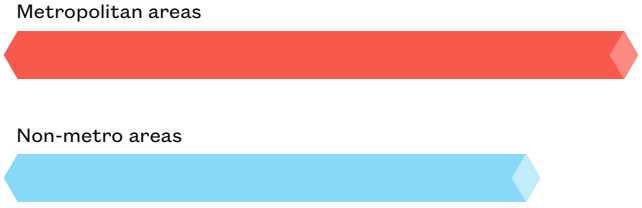
FIGURE 1

264

Number of home health aides per 100,000 people in metropolitan areas.

224

Number of home health aides per 100,000 people in non-metro areas.



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

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.

The rural portions of Washington State have just **28** home health aides per **100,000** people.

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

State	# of Home health aides per 100,000 residents	Rank, least to most
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

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.

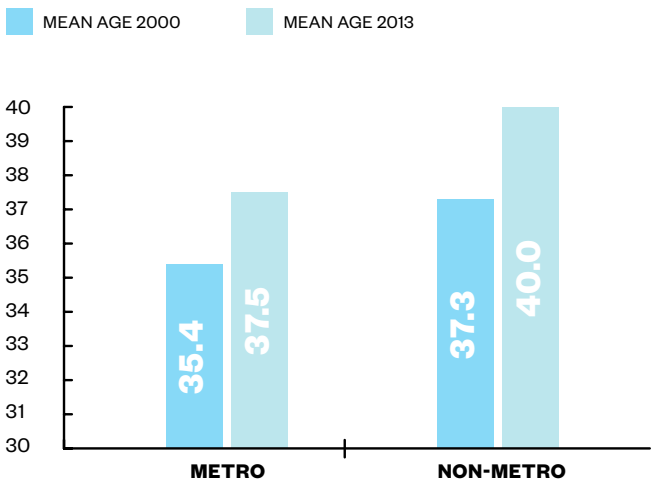
Non-Metropolitan Areas Have Greater Health Care Needs

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.[25] 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. 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.

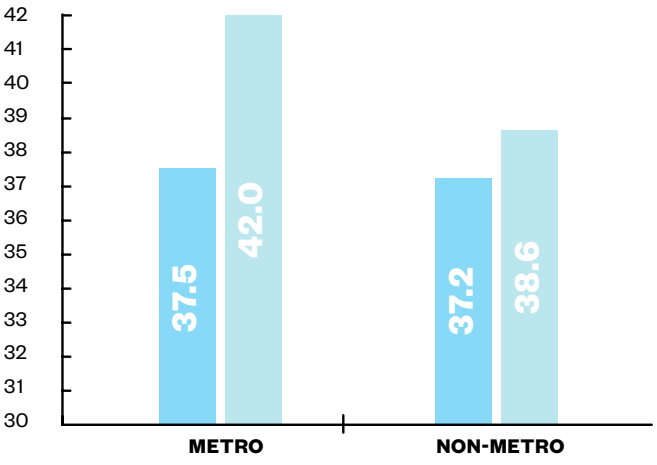
These figures make sense given recent aging trends in urban and rural America. In the last decade, many young people have left rural communities to move to urban areas in search of jobs, leaving a rapidly aging population behind. A forthcoming brief by the Partnership for a New American Economy explores this point in detail, looking at two types of smaller geographies that exist within metropolitan and

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



Source: American Community Survey, 2013

FIGURE 3: Aging Trends in Small & Rural vs Large & Urban Counties, 2000-2013



Source: Area Health Resource Files, 2012

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.[26] 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.[27] (See Figure 3.)

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 17.1 percent, were already older than age 65. In metropolitan areas, just 13.4 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 home health aides—the numbers become even more striking. In 2013, 10.5 million people living in non-metro areas were either elderly individuals or baby boomers, a figure equal to 40.1 percent of the population. In metropolitan areas, the equivalent figure was just 33.9 percent. (See Table 2.)

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.[28] 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.

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.)

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

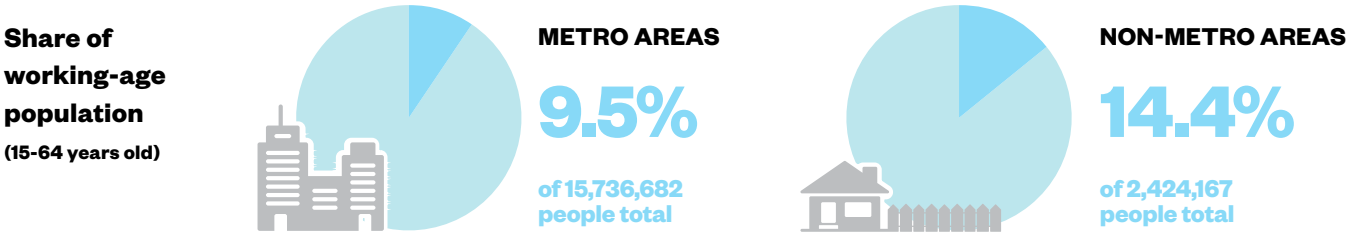
	Working Age (18-64)	Baby Boomers (Age 49-67)	Elderly (Age 65+)	Number Elderly + Boomer (Age 49+)	Total Pop.	% Elderly	% Baby Boomer	% Either
Metro	156.1	57.9	33.0	83.8	247.0	13.4%	23.4%	33.9%
Non-metro	15.8	6.9	4.5	10.5	26.3	17.3%	26.3%	40.1%

(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.

FIGURE 4: Disability Rates in Metropolitan vs Non-Metro 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-Metro 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.

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.)

TABLE 4: Incidence of Disability and Density of Senior Population vs Supply of Home Health Aides in Non-Metro 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
AL	80,565	5,900	112.1	17.2%	4	24	2
AK	4,140	1,733	8.9	7.9%	48	45	42
AZ	13,515	2,840	25.5	14.2%	35	40	4
AR	65,850	5,745	82.8	18.3%	7	13	39
CA	33,225	3,996	158.9	19.1%	19	7	25
CO	15,330	2,231	39.0	12.1%	43	43	22
CT	5,236	4,801	32.4	17.3%	12	23	5
DE	6,805	3,296	N/A	N/A	29		32
FL	44,250	3,939	18.8	17.6%	22	22	9
GA	76,900	4,192	66.3	15.4%	16	35	12
HI	9,760	2,313	32.8	17.2%	42	25	27
ID	14,685	2,720	29.9	13.9%	39	42	26
IL	52,175	3,164	120.1	18.0%	30	15	20
IN	52,200	3,730	107.6	15.9%	25	34	35
IA	36,030	2,741	88.8	19.2%	38	5	36
KS	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
ME	32,907	5,761	107.7	19.7%	6	3	34
MD	8,425	2,683	N/A	N/A	40	N/A	33
MA	7,890	9,284	N/A	N/A	1	N/A	14
MI	76,365	4,155	307.0	19.1%	17	6	41
MN	37,550	2,827	122.4	19.9%	36	2	46
MS	83,840	5,151	188.6	14.9%	10	38	15
MO	73,480	4,832	217.9	17.8%	11	19	11
MT	18,195	2,772	46.5	16.7%	37	28	3
NE	18,440	2,444	59.1	17.8%	41	21	7
NV	7,970	2,947	26.3	15.4%	33	36	N/A
NH	21,292	5,805	85.4	17.8%	5	18	17
NM	23,720	3,408	77.2	15.3%	28	37	31
NY	62,210	4,006	130.5	17.1%	18	26	44
NC	125,200	4,400	253.3	17.8%	14	20	47
ND	7,330	1,962	22.9	18.3%	47	12	23
OH	78,760	3,547	323.3	16.4%	26	29	45
OK	53,605	3,959	92.4	16.1%	21	33	30
OR	32,740	3,837	86.8	18.9%	23	10	8
PA	76,705	3,830	191.1	19.0%	24	9	43
SC	49,315	4,515	75.6	17.8%	13	17	29
SD	9,895	2,179	60.2	16.3%	45	30	21
TN	89,240	5,278	141.7	19.0%	9	8	18
TX	93,895	3,047	182.1	16.2%	32	32	28
UT	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
WA	29,315	3,533	72.3	19.6%	27	4	1
WV	48,750	5,990	111.0	18.6%	3	11	38
WI	48,665	3,154	132.7	18.0%	31	16	16
WY	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.

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.[29] 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.[30]

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.[31] 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.[32] 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.[33] 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.

Between 2012 and 2022, the number of native-born women with less than a bachelor's degree **will fall by 1.5% over the decade.**

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.[34] Despite that robust growth, however, the population of working-age women with less than a bachelor's degree in the

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

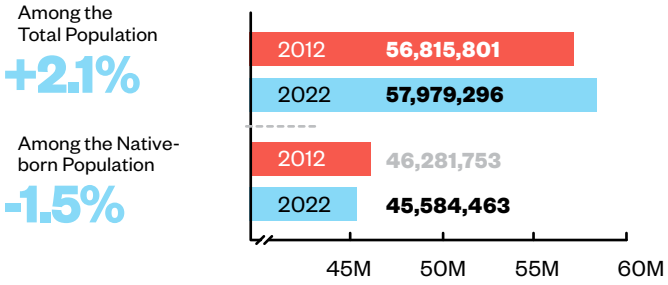
	2006	2007	2008	2009	2010	2011	2012	2013	Net Change, 2006-13	% Change
Native-Born	47,241,068	47,047,559	47,134,258	46,900,397	46,918,514	46,833,725	46,281,753	46,064,861	1,176,207	-2.5%
Foreign-Born	9,332,353	9,474,002	9,496,216	9,742,658	10,334,384	10,452,473	10,534,048	10,596,501	1,264,148	13.5%
Total	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.

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.[35] 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.[36]

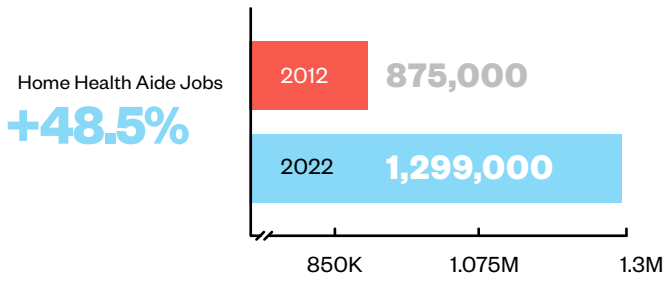
FIGURE 5

Trends Among the Population that Typically Take Home Health Aide Jobs:



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

Growth in Home Health Aide Jobs:



Source: U.S. Bureau of Labor Statistics.

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.

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.[37] [38] [39] In Illinois, Minnesota, and Connecticut, for 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.[40] [41] However, in June 2014, 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.[42]

At the federal level, the U.S. Department of Labor extended the Fair Labor Standards Act to home health aides, making them eligible for minimum wage and overtime pay in October 2015.[43] [44] These new wage requirements could help attract more workers to the field. But there are signs that foreign-born workers will remain a significant and necessary part of the overall home health aide workforce even with nationwide minimum wage and overtime protections. First, the most recent data available from the Bureau of Labor Statistics shows that even before this new policy was enacted, the average annual income for home health aides was significantly higher than that of a worker earning the federal minimum wage: home health aides earn an average of $22,400 per year, while someone earning the minimum wage earns only $15,080 per year.[45] [46]

Second, even before the minimum wage and overtime protections were mandated for home health aides nationwide, more than a dozen states already had them in place. This provides us the opportunity to look at those states and gauge the possible effects of the new policy. What we found is further evidence that foreign-born workers will continue to be a crucial part of the home health aide workforce: In the 15 states that had minimum wage and overtime protections for home health aides before 2015, native-born workers are actually less likely to work as home health aides than native-born workers in states that do not have minimum wage and overtime protections. Specifically, in the states that had minimum wage and overtime protections for home health aides by 2015, we find that native-born workers are 10.5 percent less likely to work as home health aides than native-born workers in states that do not have both minimum wage and overtime protections.

In these five states—California, Hawaii, Michigan, Arizona, and Ohio—the likelihood that a native-born worker would work as a home health aide **decreased by 6.2%** between 2000 and 2014.

In fact, when we look at the five states that introduced either minimum wage or overtime protection laws between 2000 and 2014, we see further evidence that these policy changes are unlikely to increase the likelihood that native-born workers will flock to home health aide jobs. In these five states—California, Hawaii, Michigan, Arizona, and Ohio—the likelihood that a native-born worker would work as a home health aide decreased by 6.2 percent between 2000 and 2014. Meanwhile, in the states that have always granted home health aides minimum wage and overtime protections, the likelihood that a native-born worker would work as a home health aide decreased by 0.8 percent over the same time period.[47] [48] These findings suggest that other factors aside from wages keep the native-born population from choosing these jobs. In other words, even in states with stronger wage laws, the home health industry is not attracting the native-born workers it needs to meet America's growing healthcare needs.

Yet the United States continues to face rapid and 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.[49] Given the scale of such population shifts, other avenues must be explored contemporaneously to develop an adequate number of home health aides in the future.

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.[50]

As larger shares of U.S.-born women gain higher education and graduate to more skilled work, immigrants, who are on average younger, and many of whom have less than a bachelor's degree, are often willing to do a job that fewer and fewer 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, can be physically and emotionally demanding.[51] 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.[52] 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.[53] All of this, combined with long hours, has led the profession to consistently have lower job satisfaction than other major healthcare roles, with many workers eager to "graduate" to more skilled or satisfying positions.[54] One national industry survey found a turnover rate greater than 60 percent last year.[55]

SPOTLIGHT ON

Roella Houlland

Home Health Aide

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.

Marvin describes Roella as a talented home health aide, who is "extremely trustworthy, honest, kind, **caring and hardworking**."

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.

"We have a good routine," Roella says, "**we work together like a family**, and when she is happy, I'm happy," she adds.

Yet increasingly large numbers of Americans depend on the home health care industry for essential medical care.

Given that many immigrants are just starting out in the workforce, or actively looking for less-skilled roles, it is not surprising that many foreign-born women are interested in home health aide jobs. Currently, almost one in four home health aides, or 24 percent, are foreign-born,[56] despite the fact they make up 16.5 percent of the working age population.[57] Foreign-born home health aides also express confidence in their work, with 70 percent of those polled in national surveys saying they feel "very confident" in their abilities on the job.[58] Some of the interest immigrants have in the field may derive from their tendency to be overrepresented on the lower end of the skill spectrum, making home health aide work a match for their underlying level of schooling: One recent study, for instance, found that almost 55 percent of immigrants lacked education beyond high school, compared to just 38.4 percent of the native-born population.[59] 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 health fields.[60]

Currently, almost 1 in 4 home health aides, or **24%**, are foreign-born, despite the fact they make up **16.5%** of the working age population.

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.[61] 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.[62] 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.

The United States currently lacks any sort of **temporary visa** for less-skilled healthcare workers.

An immigration policy that focused more on specific geographies or the needs of the labor market could greatly help 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.[63] In Victoria, Australia, industrial engineers, midwives, and air conditioning mechanics are eligible for state visa sponsorship.[64] 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.

Conclusion

As this brief demonstrates, the United States currently faces a shortage of home health aides that disproportionally 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 8.3 percent of the U.S. population overall lives in such non-metropolitan communities, they are home to 10.8 percent of the nation's elderly.[65]

The United States currently faces a shortage of home health aides that disproportionally affects **non-metropolitan communities**.

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.[66] 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.

Methodology

Data Sources

This study uses a variety of data sources. Data for home health aides is from the U.S. Bureau of Labor Statistics' Occupational Employment Survey (2014) and demographic data, including population age, educational levels, nativity and gender is from the U.S. Census American Community Survey (ACS) (2013) 1-year sample. Metropolitan and non-metropolitan areas are defined per the U.S. Office of Management and Budget's definition for statistical purposes. Metro areas include an urban core of at least 50,000 people and the surrounding areas, which have a high degree of economic and social integration with the urban core. Non-metro areas are defined as areas with cores of less than 50,000 and the adjacent counties/geographic localities. The Area Health Resource Files (2012) are used, when available, to further breakdown larger geographic areas into urban and rural counties. Counties are classified as urban and rural according to the County Classifications used by the U.S. Department of Agriculture's Economic Research Service.

Demographics and Population Projections

The U.S. Census ACS 1-year sample is used to report population demographics for metro and non-metro areas nationally and by state. Using a straight-line projection of average yearly changes during the 2003-2013 period, the rate of growth of the population is calculated to arrive at projected numbers of future retirement ages as well as the increase in the elderly population. Variables from the ACS 2013 1-year sample are used to show disability rates for the U.S. population. Those reporting any one or more of the following: 1. independent living difficulty; 2. self-care difficulty; 3. vision difficulty; 4. hearing difficulty; 5. ambulatory difficulty; and or 6. cognitive difficulty, are classified as having a disability. Additional data from the U.S. Census, Bureau of Labor Statistics Old Age, Survivor, and Disability Insurance (OASDI) (2013), are used to identify recipients of Social Security Disability Insurance within metro and non-metro areas.

Labor Market Trends

Reported labor market projections, including wages and job demand growth rates are reported from the U.S. Bureau of Labor Statistics. Trends among the population that typically takes home health aide jobs are derived using a straight-line projection of average employment rates between 2003 and 2013, of native- and foreign-born home health aide workers. Trends in the likelihood that native-born or foreign-born workers would be home health aides based on the existence of overtime protections for home health aides were derived from data from the 2000 decennial U.S. Census and from 1-year samples from American Community Surveys between 2007 and 2014. Data on each state with overtime protections for home health aides was analyzed to get the share of home health aides that were either native-born or foreign-born before and after the passage of the state's overtime protection laws for home health aides.

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